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# Hawaii Medical Journal

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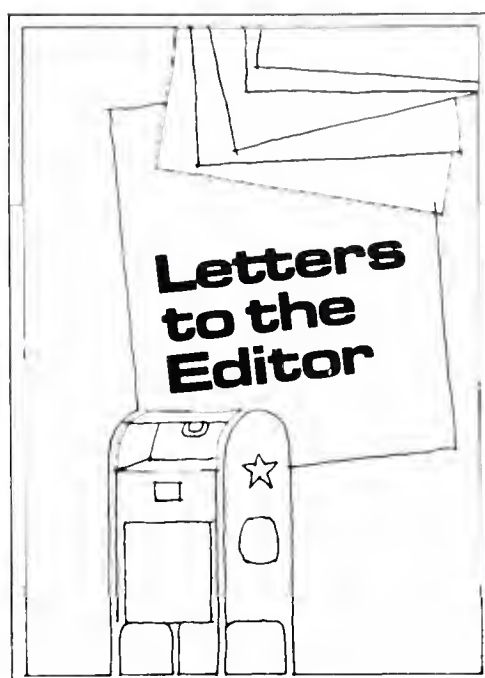
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## To the Editor:

On reading your *Arnold to Califano* letter, I am reminded again how frequently we find the preposterous becoming commonplace.

Item: a group of seven physicians in Wahiawa outgrew their small quarters, and after searching for several years, recently leased a bigger place three blocks away. Because their move meant spending "more than \$150,000" (for walls, and furniture, and fixtures), they couldn't move a single examining table until they filed a "Certificate of Need," with the local bureaucracy. This "CON" is a complicated kind of impact statement, by which a series of subcommittees and councils of the State Health Planning Council (HSHCC and SHPDA) decide whether or not the proposal is in the best interests of the area consumers.

The spirit of the law is to examine the impact of big-ticket purchases on local health costs. But to apply the letter of the law to a group of established physicians moving down the street, and spending \$20,000 per head for new quarters is ridiculous!

So here come the doctors, through round after round of hearings (called "JAR" and "SAC"), defending to the laypersons (by law 51% "consumers," which seems to mean being wholly unaware of the issues) why they need to move down the street. And patiently the physicians explained to citizens who didn't know CBC from DSS why it is medically necessary to do a few lab tests in the office (the consumers finally agreed to permit this) and why they wanted to dispense some drugs as a convenience (they were turned down), and about x-ray machines (denied), and insurance "assignment," and RVS, and on and on into the night.

The whole business was a nightmare of "hyperdemocracy"—the sovereignty of the unqualified individual, added into a mass; the spectacle would have been funny, if it weren't so sad. These "consumers" of course, while variously hostile or somnolent, were also to be pitied. They were but the befuddled infantry, goaded by a hierarchy hidden in the bureaus.

I think the JAR approved the CON—or at least recommended that the SAC refer it to the next layer in the multi-tiered morass. I hope the doctors can move before their present lease expires, but the outlook is uncertain, depending on the SAC, or the HSHCC, if

*continued page 30*



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Stead W.W. and Bates, J., in Harrison's Principles of Medicine,  
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**Reference:** Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.



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# Clinical Applications of Biofeedback: A Summary of Research 1974-1978

DANNY WEDDING, M.A.,\* and WILLIAM T. TSUSHIMA, Ph.D.,\*\* *Honolulu*

● *Studies of biofeedback dealing with headache, heart rate control, hypertension, pain management, muscle reeducation, and epilepsy are reviewed. Biofeedback, while not a panacea, holds considerable promise as a primary or ancillary treatment for a wide array of disorders. Whether these disorders could be treated more efficiently—and with less expense—through alternative treatment methods such as relaxation is a question that remains to be answered.*

In 1974, Blanchard and Young<sup>1</sup> published an exhaustive analysis of clinical biofeedback literature. The current review will attempt to update the Blanchard and Young article and will be largely limited to articles published since 1974. In addition, it will address the question of utility across a wider range of disorders than those examined by Blanchard and Young.

## **Tension Headaches**

Tension headaches, a common complaint, result from sustained contraction of the muscles in the face, scalp, and neck. Early workers in the field of biofeedback were quick to see a possible application of EMG technology in treatment of the tension headache patient. Research in this area was promoted by a major study by Budzynski, Stoyva, Adler, and Mullaney<sup>2</sup> demonstrating significant reduction in muscle contraction headache activity in a group of 6 patients treated with 16 20-minute EMG sessions. No treatment gains occurred in a pseudo-treatment group or in the waiting list controls. The findings of this original study have been repeated by several other investigators.<sup>3,4,5</sup>

Effort has been made to compare the effectiveness of EMG-assisted training with general relaxation procedures. Chesney and Shelton<sup>6</sup>

found that a muscle relaxation treatment and a combined muscle relaxation and biofeedback treatment were equally more effective than either a biofeedback treatment alone or a no-treatment control in reducing headache frequency. With slightly different results, Hutchings and Reinking<sup>7</sup> reported that EMG relaxation training and EMG relaxation training combined with autogenic-relaxation training showed significantly better results, compared to the autogenic-relaxation training alone, in terms of reduced headache activity. In toto, the results suggest that both general relaxation training and EMG feedback offer viable and effective treatment strategies for the tension headache patient. Neither technique presently appears to have a clear advantage over the other; however, the clinician is well advised to employ both progressive relaxation (or a similar general method) and EMG training in treating headache patients.

## **Migraine Headaches**

The earliest attempts to control migraine headache grew out of the observation at the Menninger Foundation that one subject could prevent migraine headaches by employing the autogenic hand warming exercises she was learning for an experiment entirely unrelated to headache activity. Quickly picking up on the implications of this fact, Sargent, Green, and Walters<sup>8</sup> conducted several studies to investigate the effects of handwarming in the treatment of migraine. In the initial study improvement was noted in 30 to 40 percent of the 75 patients studied, using a combination of autogenic training, biofeedback training, and home practice. In the second study, 12 of 19 patients were clinically rated as definitely improved following training. Both of these studies, while seminal, suffered

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from inadequate baseline data and the absence of any attempt to control for expectancy or placebo effects.

Diamond<sup>9</sup> has reported the results of a large sample investigation of migraine headache patients (N=273). Temperature feedback was effective in 40% of all cases treated with thermal biofeedback. Diamond maintains that treatment was most likely to be unsuccessful with depressed patients, and suggested that adjunct psychotherapy may be required in the treatment of many migraine patients.

### Hypertension

Applying biofeedback techniques to the problem of hypertension, several investigators have been able to demonstrate average systolic decreases of 5 to 17 mm Hg within a single session using normotensive subjects and direct blood pressure feedback.<sup>10,11</sup> Similar success has been reported with hypertensive subjects by Benson *et al*,<sup>12</sup> Endler and Eustis,<sup>13</sup> and by Kristt and Engel.<sup>14</sup> However, more substantial gains are noted in the hypertensive subjects (eg, an average decrease of 16.5 mm Hg for 5 of the 7 patients in the Benson study and an average decrease of 26 mm Hg systolic for the patients in the Blanchard *et al* study).

Blanchard and Epstein<sup>15</sup> have recently reported the results of a comparative study of direct biofeedback of blood pressure, EMG feedback as a means of inducing relaxation, and simple self-directed relaxation practiced on a regular basis. Contrary to the investigators' expectations, all 3 groups improved equally. These results, along with the others reviewed, suggest that while biofeedback of blood pressure can be effectively employed as a treatment for hypertension, it is not any more effective than simple EMG biofeedback, which in turn is not clearly superior to other forms of relaxation training.

### Heart Rate Control

To date, heart rate biofeedback has been used principally in cases of atrial arrhythmias, auriculoventricular arrhythmias, premature ventricular contractions, and heart block.<sup>16</sup> Weiss and Engel<sup>17</sup> presented data on 8 patients, each treated as a systematic case study. All patients suffered from premature ventricular contractions (PVC's) of 10-20/minute. Following treatment, PVC's were decreased in 5 of the 8 subjects, and improvement was maintained at a 3-to-21-month follow-up. These results were later replicated by Engel and Bleecker<sup>18</sup> and Pickering and Gorham.<sup>19</sup> Miller<sup>20</sup> has reported replication of the cardiac arrhythmia results in his own lab and suggests that it is unlikely that the effects observed can be attributed to placebo factors in view of the fact that a number of the patients had been extremely resistant to other

forms of therapy.

A series of case studies involving the treatment of tachycardia<sup>21</sup> and "cardiac neurosis"<sup>22</sup> are provocative and suggest that biofeedback of heart rate may prove to be a viable approach to cardiac control for some patients. However, controlled clinical studies are absent and it is only possible to speculate about clinical effectiveness for large groups of heart patients.

### Pain Control

Melzack and Perry<sup>23</sup> conducted a systematic study using 24 patients suffering from pain of definite but mixed organic etiology (eg, peripheral nerve injury, cancer, arthritis, phantom limb pain, etc.). Patients were randomly assigned to one of three groups: (1) alpha training, (2) hypnosis, or (3) both. The first two procedures were ineffective in reducing pain, but the combined procedure resulted in a substantial reduction (33% or greater) of pain for 58% of the patients in that group. The authors conclude that the contribution of alpha training lies not in generation of alpha activity *per se* but rather in providing distraction, suggestion, relaxation, and a sense of control over pain.

In more recent studies, Carlsson and Gale<sup>24</sup> treated 11 patients suffering from temporomandibular joint pain and, on follow-up, found 8 to be symptom free or significantly improved. Hendler, Derogatis, Avella, and Long<sup>25</sup> used EMG biofeedback to treat 13 patients drawn from the neurosurgical pain clinic at Johns Hopkins Hospital. Patients suffered from either post-traumatic or degenerative pain and had suffered from their condition for an average of 1.9 years. Substantial reduction in pain was noted in 6 of 13 patients (46%).

### Raynaud's Disease

Although relatively rare, Raynaud's disease has been treated successfully with biofeedback training in blood volume. Schwartz<sup>26</sup> reports two cases in which biofeedback was attempted: in one subject, symptoms remitted and the patient remained symptom free for over a year, while the other patient became discouraged and dropped out of treatment prior to completing 10 sessions. While no controlled group outcome studies have appeared to date (and may be impossible due to the relative infrequency of the disorder), available evidence suggests that biofeedback should be the treatment of choice for Raynaud's disease and should certainly be tried before resorting to surgical sympathectomy or other irreversible procedures.

### Epilepsy

One of the newest and most fascinating applications of biofeedback can be found in recent attempts to train epileptic patients to control



brainwave patterns in order to ward off an impending seizure. This line of investigation appears especially promising, since many epileptics report an aura which precedes their seizures and is an infallible indicant of the approach of a fit. Stermann and Friar<sup>27</sup> trained a 23-year-old woman to produce a specified rhythm (12-14 hz) in the sensory motor area with EEG feedback. Prior to training, the patient had experienced an average of 2 seizures per month; following training, the frequency of seizures had decreased to approximately one every 3 months. The authors report permanent EEG changes were present following training.

Lubar and Bakler<sup>28</sup> have recently reported on 8 patients given sensorimotor rhythm training. Of the patients, 6 responded with marked reductions in seizure frequency while the other 2 reported seizures which were shorter and less severe (but no less frequent). Not every researcher has met with this same degree of success.<sup>29,30</sup> Despite the failures (which may be due to the marked between-subject variance typically noted in electroencephalographic activity in epileptic patients), considerable evidence suggests that brain-wave training may help patients who are unresponsive to medicine.

### Miscellaneous Applications

Space will not allow a full description of each area where biofeedback has been successfully applied. However, it is important to note that a major application of biofeedback is found in the area of rehabilitation psychology and neuromuscular reeducation. John Basmajian has been the leading researcher in this area. In the only controlled study to date, he found that a group of stroke patients suffering from chronic foot drop, treated with physical therapy plus biofeedback, developed strength of dorsiflexion and range of motion twice as great as that of a group of patients receiving only physical therapy.<sup>31</sup> Numerous case studies demonstrating the utility of biofeedback in a variety of neurological and neuromuscular disorders can be found in Inglis, Campbell, and Donald.<sup>32</sup>

A list of other disorders successfully treated with biofeedback reads like the index of a first

year medical text and includes—but is not limited to—duodenal ulcers, elevated intraocular pressure, subvocalization, anxiety, asthma, depression, writer's cramp, fecal and urinary incontinence, tinnitus, impotence, cerebral palsy, insomnia, chronic dysphagia, diabetes, atopic dermatitis, stuttering, tardive dyskinesia, alcoholism, gastrointestinal disorders, postural sway, visual acuity, and relief of tension in the throat muscles of a woodwind musician. It is not surprising that biofeedback has been touted as a cure-all by the mass media. However, with few exceptions, all of the above examples are limited to case studies, many not yet replicated or confirmed. Nevertheless, the numerous studies illustrating self-control over a variety of physical functions demonstrates the soundness of the basic principles of biofeedback.

### Conclusions

Sufficient evidence is currently available to suggest that biofeedback offers a viable treatment option for a variety of physical disorders. It is neither the panacea that its proponents expected, nor the simple manipulation of placebo and expectancy suggested by its detractors. It is likely that much of the effectiveness of several biofeedback techniques (eg, EMG training for hypertensives) is directly related to a generalized feeling of relaxation and well-being produced by the treatment. Although evidence is, as yet, inconclusive, similar effects can be produced by a variety of other techniques (eg, progressive relaxation) with less expense and less investment of the therapist's time.

However, in other areas such as training epileptics to generate the sensory motor rhythm or training in sphincter control, the results obtained seem fairly directly related to the training experience; relaxation *per se* does not seem to be a major component of treatment.

Whatever the contribution of relaxation, the diversity of disorders treated with biofeedback is impressive, and it is likely that increasing technological sophistication will generate many new applications, so that biofeedback will become an increasingly important part of the clinical armamentarium.

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*Children in an institution . . .*

# Psychiatric Problems of Hawaii's Children: Analysis of Five Years of Admissions to a Children's Psychiatric Ward

JANE A. WALDRON, D.S.W.,\* and EBERHARD MANN, M.D.,\*\* *Honolulu*

Leahi Hospital's Children's Mental Health Unit is a 12-bed 5-day-a-week in-patient treatment unit for children between the ages of 4 and 12—the only one of its kind in Hawaii. The Children's Mental Health Unit is a State of Hawaii Department of Health facility, with clinical and medical leadership provided by the John A. Burns School of Medicine, Department of Psychiatry. The Unit serves the entire State and offers diagnostic and treatment services to children with a wide range of psychiatric disabilities from reactive disorders to psychosis. The aver-

age length of stay on the in-patient unit is from 3 to 6 months.

To identify what portions of our child population in Hawaii are at greatest risk for admission to the psychiatric in-patient facility, admission data, age, sex, ethnic background and diagnosis were analyzed. The period studied includes the 5 years from June, 1973, through June, 1978.

## Method

Data were obtained through chart review. The authors recognize the problems that exist in achieving diagnostic consensus among psychiatrists. The diagnoses used in the data analysis represent the authors' best judgement about the diagnoses of the children in the sample. The

\*Assistant Professor of Psychiatry, John A. Burns School of Medicine

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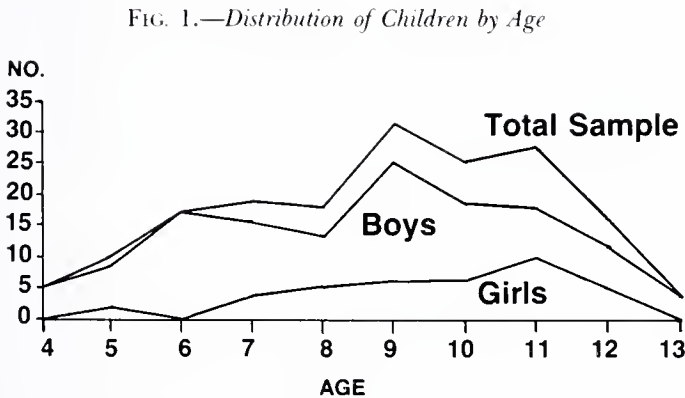
Accepted for publication October, 1978.

diagnostic categories used in this study are those of the Group for the Advancement of Psychiatry (GAP).<sup>1</sup> The authors find the GAP classification more developmentally and dynamically oriented than is the more adult-oriented Diagnostic Statistical Manual (DSM) II classification. The only exception is the diagnosis of minimal brain dysfunction (MBD), which often occurs in combination with other GAP diagnoses.

Results

Over the 5-year period studied, 173 children were admitted to the Children's Unit. Of these, 36 (21%) were girls and 137 (79%) were boys. In the State of Hawaii, sex distribution of children in the same age range (4-13) is much more evenly distributed, there being 51% boys and 49% girls.<sup>2</sup> Boys outnumber girls 5 to 1 in the present sample; this compares closely with the general trend in emotional disturbance in children nationally. In severe conduct disorders, boys outnumber girls 12 to 1; whereas in developmental disorders, boys outnumber girls 2 or 3 to 1.<sup>3</sup>

With regard to age distribution, the average age of patients on the Children's Unit was 8.8 years. The mean for girls (9.5) was about one year older than that for boys (8.6). Figure 1 shows the age distribution of children in the Leahi sample. The distribution of children in Hawaii by age is much more evenly spread within the 4 to 13 age group, approximately 5% being at each age.<sup>2</sup> Boys and girls in the general population are almost evenly distributed at each age, the mean age for the entire group, as well as for boys and girls separately being at 8.53.



Thus, boys tend to be referred for hospitalization one year earlier than girls, and children in the middle age range are more often hospitalized than younger or older children. This is understandable in view of the efforts of most mental health professionals to intervene early and use the least drastic, less costly interventions first.

Most children who are hospitalized at Leahi have had outpatient treatment first. By age 8 or 9, schools have had several years to evaluate and treat learning problems that exist. After several years with a student, educators can usually

clearly identify children in need of further help. The lower census of children in the hospital at 12 and 13 years is due to the nature of the Leahi Unit, its relatively short term orientation, and its program focus on latency age children. Many of the 12 and 13 year olds referred for treatment are children with long histories of problem behavior for whom 3-6 months, 5-day-a-week treatment will not be adequate to effect deeply entrenched characterologic behavior. Many of these children are already showing delinquent or strong predelinquent tendencies, and a longer term and different type of setting is indicated.

A look at ethnicity reveals some interesting data (Table 1). The percentages of Japanese, Filipino and Chinese children admitted to the Unit are quite low, compared with their occurrence in the State's population. Caucasians, Cosmopolitans, Blacks and Samoans are over-represented.

TABLE 1.—Ethnic Distribution

ETHNIC GROUP	% IN STATE	% IN CHILDREN'S UNIT
Caucasian	29.8	45
Japanese	26.6	3.5
Pt Hawaiian		
Cosmopolitan*	16.4	23.8
Filipino	10.1	.6
Non-Pt Hawaiian		
Cosmopolitan	9.2	19
Chinese	4.3	2.5
Korean	1.3	.6
Black	1.2	4
Samoan	.5	1.2
Puerto Rican	.4	.6

\*Cosmopolitan is used here to indicate a child whose ancestry includes two or more nationalities.

Of the Caucasian and Black populations in this 5-year sample, a large portion, 54% and 43% respectively, are from military families. These families are often subject to multiple moves, long or sporadic absences of father from home, and in most cases are in Hawaii without benefit of a family support system. It can also be speculated that children who fall into the Cosmopolitan ethnic group are in many cases cut off from the organizing and supportive nature of a single cultural heritage. This is not necessarily bad, but may tend to put a child at greater risk because of the tendency for a breakdown in culturally based child-rearing methods and of the increased potential for culturally-related conflict between parents.<sup>5</sup> The low admission rate of children of Japanese, Chinese and Filipino ancestry coincides with the under-representation of these ethnic groups on the roles of prisons and social agencies. In addition, these ethnic groups are also under-represented as welfare applicants.<sup>6</sup> In general these groups have strong family ties and resources. (The Unit has never had a pure Hawaiian child.)

The largest percentage of children admitted to the Children's Unit were diagnosed personal-



ity disorder (45%), followed by MBD (23%), developmental deviation (20%), neurosis (13%), reactive disorder (10%), psychosis (8%), and mental retardation (MR) and organic brain syndrome (2% each). MBD and MR most often occurred in combination with another diagnoses, eg, personality disorder and MBD, or developmental deviation and MBD, or MR and reactive disorder. The preponderance of severe emotional disturbance is not surprising when one considers that children are hospitalized for treatment only as a last resource: when treatment on an outpatient basis is either ineffective or not feasible because of child abuse; or because the symptomology endangers the child or the community, eg, runaways of a young child, or persistent fire setting. Most of the personality disorders involved impulsive, aggressive children whose misbehaviors included fighting, lying, stealing, poor peer relations and poor school performance. Schools and families were at their "wit's end" with these children.

When one considers the occurrence of each diagnosis in girls and in boys (Table 2), it is difficult to say why MBD occurs at such a low rate (8%) in girls compared with boys (26%), though this compares with national findings.<sup>7</sup> Of the girls, 28% were neurotic as opposed to 9% of boys; and 17% girls showed reactive disorders, against 9% of boys. In contrast, boys received a diagnosis of personality disorder in higher percentages (48%) than in girls (33%). The diagnosis of developmental deviation is made more frequently in boys (23%) than in girls (11%).

TABLE 2.—Percentage of Diagnosis According to Sex

	<u>%</u> <u>BOYS</u>	<u>%</u> <u>GIRLS</u>
Personality Disorder	48	33
MBD	26	8
Developmental Deviation	23	11
Reactive	9	17
Neurotic	9	28
Psychotic	8	8
MR	3	3
OBS	2	3

Boys present with diagnoses which suggest severe behavior problems (personality disorder) and organic involvement (developmental deviation), whereas girls are more heavily represented in the less severe and more functional diagnostic categories (neurosis and reactive disorders). The fact that many more girls (17%) than boys (9%) are hospitalized for reactive disorders may indicate that sudden upset or acting-out in girls is of more concern to parents, schools and admitting physicians than similar behavior in boys. These situations most often involved child abuse or severe family disorganization and occurred in young children (ages 4-6). In such cases it was felt that placement outside the home would prevent

overwhelming and potentially disorganizing stress to the child. In many cases, personality disorder and developmental deviation were used in combination with diagnosis of MBD and most often this was in boy patients.

Diagnosis by ethnic group is shown in Table 3. In Caucasian, Cosmopolitan and Japanese groups, personality disorders ranked highest as the most common diagnosis. MBD was very high in hospitalized children of Japanese ancestry (67%) and accompanied every diagnosis of personality disorder and developmental deviation in these children. This would lead one to speculate that children of Japanese ancestry rarely present for hospitalization with pure behavior problems without some organic basis, or that they do not present for hospitalization unless behavior presents extreme stress on the family. Other groups manifested MBD and the question of organic involvement between 18 and 29% of the time.

In the small group of children of Chinese ancestry, all three children were psychotic and all were boys. Again, one wonders about the possibility of an organic basis in disturbances of hospitalized children of Chinese ancestry and about the tendency of the members of this ethnic group not to present their children for hospitalization unless the problem is extreme.

Reactive disorders occurred with very low frequency in part-Hawaiian Cosmopolitan children and in the oriental and Samoan groups. Perhaps this is due to the high prevalence of extended families and the availability of a support system in times of crisis. Caucasian, Cosmopolitan and Black children were the only ones who received diagnosis of reactive disorder; this fits with the earlier speculation that often in these groups there is little family support resources. In general, children hospitalized for severe conduct problems without organic factors (MBD) tended to be Caucasian or Cosmopolitan. It is hazardous to make conclusions about the ethnic groups with only 1 or 2 children in them.

Discussion

After examining the data on age, sex, ethnic background and diagnosis, one can build a profile of the kind of children most often hospitalized in Hawaii's Children's Mental Health Unit. The 8- or 9-year-old Caucasian or Cosmopolitan boy who presents with a severe conduct disorder, considered to be a personality disorder, with or without minimal brain dysfunction, is the most usual. Speculations regarding etiology might be related to family organization, family support systems and the clarity of culturally supported child-rearing systems. Children of Oriental ancestry, ie, Japanese, Chinese and Filipino, tend to be under-represented and to have minimal brain dysfunction or psychosis as diagnoses, suggesting some possi-



TABLE 3.—Percentage According to Ethnic Group and Diagnosis

	N=78	N=33	N=41	N=7	N=6	N=3	N=2	N=1	N=1	N=1
		NON-HI	PI-HI							
	% CAUC	COSMOP	COSMOP	BLACK	JAP	CHIN	SAM	KOREAN	FILIP	PUERTO RICAN
Personality Disorder	44	52	46	29	50	0	0	100	0	100
MBD	24	18	20	29	67	0	0	0	0	0
Developmental Deviation	22	18	22	14	17	0	50	0	0	0
Neurotic	14	9	17	0	17	0	50	0	0	0
Reactive	13	15	02	29	0	0	0	0	0	0
Psychotic	5	3	7	29	0	100	0	0	100	0
MR	3	0	2	0	17	0	0	0	0	0
OBS	1	3	2	0	0	0	0	0	0	0

bility of organic involvement, or suggesting strong reluctance to seek help unless the problem is extreme.

In addition, it may be that children from homes with clear definitions of roles, functions and expectations tend to have an easier time internalizing societal value systems and less frequently present with severe conduct disorders. This seems to be the case in Oriental families, and

may account for the under-representation of Japanese, Chinese and Filipino children in our hospital group.

Further study of all these questions is necessary. What are now speculations must be systematically studied in order to develop preventive programs, so that maladaptive responses can be interrupted before they become chronic and painful to everyone concerned.

#### REFERENCES

1. Committee on Child Psychiatry. *Psychopathological Disorders in Childhood: Theoretical Considerations and a Proposed Classification*. Group for the Advancement of Psychiatry, New York, 1966.
2. Hawaii Department of Health, Research & Statistics Office, 1970 Census Data.
3. *DSM III: Diagnostic Criteria Draft*. Task Force on Nomenclature & Statistics, American Psychiatric Association, 1-15-78.
4. Schmitt R: Historical Statistics of Hawaii, University Press of Hawaii, Honolulu, 1977.
5. Mann E, Waldron J: Intercultural Marriage and Child Rearing. *Adjustment in Intercultural Marriage*, ed. Tseng W, McDermott J, Maretzki T, University of Hawaii Press, 62-80, 1977.
6. Hawaii Association of Asian & Pacific Peoples: A Shared Beginning. The Proceedings of the HAAPP Statewide Mental Health Conference, June 14 & 15, 1974. (mimeographed)
7. Wender P: The Minimal Brain Dysfunction Syndrome. *Ann Review Med* 26:45-61, 1975.



## Guest Editorial

### MD Advertising

We are now beginning to feel the effect of the latest Dubious Directive from Washington, intended to save the people's money by spending it.

Physicians are being contacted by the Hawaiian Telephone Company, with solicitations for ads in the coming issue of the Directory.

We are urged to seize "the opportunity to advertise" now, since "everyone will be doing it" soon, and presumably an unadorned phone listing will scarcely be visible in the future. (And you know what *that* means!)

If we all sign up for bold type and big boxed listings, we can each spend an extra \$50-\$70 a month in order to maintain a uniform appearance in the Yellow Pages. Sounds like running faster, just to keep up with one another.

Of course, the listings already *are* uniform, so the only party to gain from this scheme will be the telephone company. And guess who pays for it all?

Once it starts, there may be no stopping the escalation of this promotional nonsense. The law merely prevents official restrictions on advertising. If we could all reach a consensus, sort of a "gentlepersons agreement" not to be baited into this advertising game, we could spare our patients further misguided Federal assault.

JOHN M. CORBOY, M.D.

### Let's Avoid The Factors That Have Damaged Labor's Political Clout

Our AMA federation must shun the internal damage that has made organized labor much less effective in Washington, D.C., than the publicity accorded its leaders might suggest.

"Big labor isn't very big anymore," liberal syndicated columnist Nicholas von Hoffman

wrote in the December issue of *Harper's*, adding, "the labor lobby has come down with pernicious anemia."

He further said:

"Without a kick in the pants of the kind unions can no longer deliver, labor must suffer increasing rejection from the national government. The last session of Congress saw organized labor lose almost everything it wanted, in particular the labor-law reform bill. . . . That bill would have eased the unions' organizing efforts."

As the primary reason for the loss of clout, von Hoffman cites the falloff in union membership to only about 20 per cent of the labor force. "Since 1974, unions have lost more than half a million members, while in the same period the economy added 6 million new jobs."

The lack of unity in the union movement could well be an additional reason, we believe. For example, the only three unions with more than a million members (according to the 1978 *World Almanac*)—the Teamsters, United Auto Workers, and National Education Association—are unaffiliated with the AFL-CIO.

In contrast with organized labor, the AMA has been effective in Congress and has improved its relations with the White House. To remain effective, however, our federation must grow in its proportion of the total number of physicians and in unified membership.

In the 1977-78 Congress, our federation was instrumental in the demise of such offensive bills as:

- A bill to extend Federal Trade Commission jurisdiction to non-profit organizations, which would include the AMA, its component societies, and medical-specialty societies. Along with eliminating Congressional sanction of the FTC's current anti-trust action against physician solicitation of patients, the bill's death is likely to help us if the FTC administrative judge's adverse ruling on the issue has to be carried as far as the federal courts.

- A Health Planning Act amendment that would have extended certificate-of-need provisions to purchase of new equipment by physicians' offices.

- Mandatory cost containment, as contrasted with the voluntary effort spearheaded by the AMA, the American Hospital Association, and the Federation of American Hospitals, with splendid support from their state bodies.

- The proposed Clinical Laboratory Improvement Act, which would have set national standards for the training of lab technicians and harassed lab procedures in many physicians' offices.

- The drug regulation reform bill, which would have further muddled the development, distribution, and use of drugs.

Let's sustain our impact. And let's all work for the membership growth and unity that are needed to sustain it!



# Letter to an Advertising Physician

Dear Doctor:

The world moves. My doctor father got into a serious hassle with my doctor grandfather, in 1911, because the old gentleman would not send patients bills. He finally gave in, and did it.

Not many of my generation broke with the standards of their fathers, but in your generation there is a good deal of disagreement with the old standards, in more ways than one. We have residents who wear sandals at work and look unwashed; certainly they are often unbarbered, and uncombed.

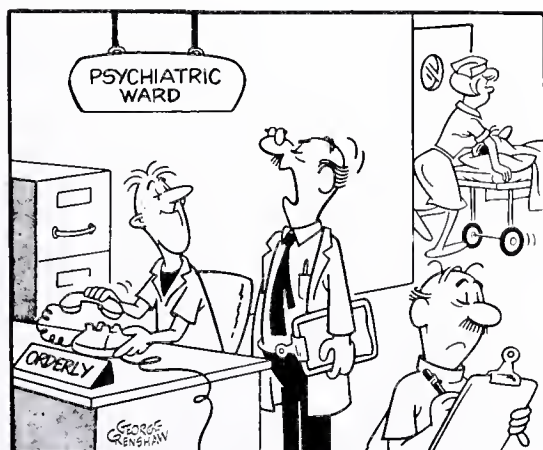
And we have physicians who advertise; more, who solicit patients. I find this just as objectionable as my grandfather found the sending of bills; and though it is entirely possible that in 20 or 30 years my objections will seem just as groundless as his, this is still only 1979.

I don't have to proclaim my naivete; it sticks out like a sore thumb. But it doesn't go so far as to make me think we can either reform doctors of your persuasion, or discipline you without incurring prohibitive legal expenses.

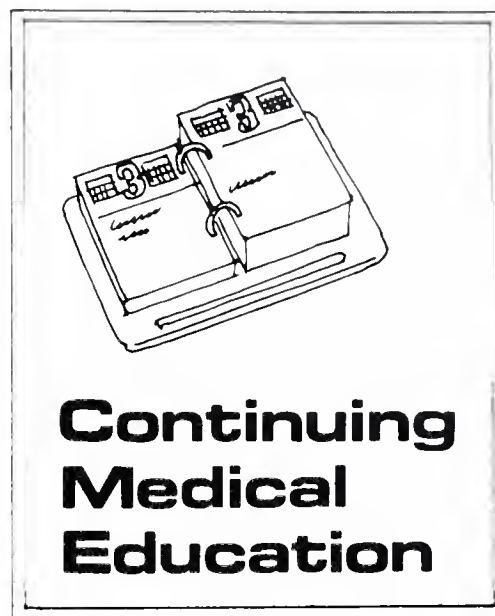
Your analogy between not liking doctors who solicit patients, and not liking blacks, Jews, Irishmen and so on, seems pretty strained to me. Should I accept any and all sorts of aberrations of behavior on the same ground? I am ethnically color blind, and so pro-Jewish that it was a source of utter astonishment to me to find that both of my first two associates in practice, both Jewish, just couldn't live with group practice or with me. I don't think you have a point there.

So go your way rejoicing, but without the approval of a great many of your colleagues, including me. If what you are doing were to become widespread, there would be little need for CME or medical societies and such; mutual professional respect would largely degenerate into advertising rivalry. Dependence on professional skill plus charisma is, I think, good for standards of medical performance, and I regret the threat to it posed by professional advertising.

HLA, JR.



"Just say we're terribly busy, Simpkins. Don't say it's a madhouse!"



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1½ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds. 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.
9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.

##### Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

##### Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.

6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

#### Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

#### Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

#### Kuakini Medical Center

1. Visiting Professor Program
2. Department of Med. evening mtg., 6:00 p.m.
3. G.I. Conference, 4th Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, 4th Wednesday, every month, 8:00-9:00 a.m.
5. Oncology Conference, every Thursday, 7:30-8:30 a.m.
6. Surgical Conference, every Friday, 1:00-2:00 p.m.
7. Ophthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
8. Medical Mortality & Morbidity Conference, 4th Tuesday, every month, 1:00-2:00 p.m.

(Contact CME Dept.-Kuakini for further information)

#### The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium  
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium  
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium  
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

#### St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

#### Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.

2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

#### Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

#### Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: 1, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

#### SPECIAL EVENTS

- |                      |  |
|----------------------|--|
| Feb. 1979            | Workland Recording Workshops, Coll of Am. Pathologists, 7400 N. Skokie, IL 60077. Held at Sheraton Waikiki, Honolulu. 15 hrs.  |
| Feb. 6-9, 1979       | Perinatal Med. USC Sch. of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina, Maui. 5 days, 19¼ hrs.   |
| Feb. 15, 1979        | "Providing Hlth. Care in a Developing Country." 1979 Ira Hiscock Public Lecture—4:30 P.M. Biomedical Sci. Bldg. B-103, Schl. of Pub. Hlth. Speaker: Dr. B. Sankaran, Dir. Gen. of Hlth. Serv. Gov. of India.                         |
| Feb. 19-22, 1979     | Mid-Winter Traveling Med. Educ. Course, Kansas City SW Clin. Soc., 2220 Holmes, KC, MO 64108. Cosponsor: U of MO-Kansas City Sch. of Med. Held at Maui Surf Htl., Maui. 4 days, 16 hrs.  |
| Feb. 19-25, 1979     | Financial Planning/Med & Dental Prac Management, Med Communications & Servs Assn. 1107 NE 45th, S 315, Seattle, WA 98105. Held at: Sheraton-Molokai, Box 1977, Kepuhi Beach, Maunaloa, Molokai.                                      |
| Feb. 26-Mar. 2, 1979 | Surg. Diag. & Therapy, The Phil Thorek Postgrad. Courses, 850 Irving Park Rd., Chicago 60613. Held at Maui. 5 days.  |
| Mar. 6-10, 1979      | U of H Sports Med. Course, Contact: HI Conf. Servs., Harold Brown, P.O. Box 25055 or (808) 377-6445, Honolulu 96825. Reg. Fee HI Residents \$100. Cosponsor: AAFP. Held at Princess Kaiulani Htl. Waikiki, Honolulu. 5 days, 18 hrs. |
| Mar. 26-28, 1979     | Pediatric Post Grad. Seminar—"Problems of Teenage Sexuality." Kap-Childrn. Med. Cntr. For info write: W. Schiner, 1319 Punahou St. Honolulu, 96826 (808) 947-8511.   |



- Mar. 31, 1979 "Overview of Hypertension in Hawaii"—2-5:00 P.M. 3 hrs. Cat. I. Held at: Pagoda Htl., Honolulu. Sponsors: HMA, DHEW-NHBL, Dept. of Hlth., HI Heart Assoc. No Fee. Contact: Stephen Wallach, M.D. (808) 521-3851.
- Apr. 8, 1979 "Problems in Human Sexuality" 8:30 a.m.-4:55 p.m. 6½ hrs. Cat. I. Held at: Ilikai Htl., Honolulu. Lederle Labs., HI Nurses Assoc. HMA, HI Pharm. Assoc. No Fee. Contact: CME Dept.-HMA (808) 536-7702.
- Apr. 15-21, 1979 Current Concepts in OB/GYN, Mem. Hosp. Med. Ctr. of Long Beach-Women's Hosp. 2801 Atlantic Ave., Long Beach, CA 90801. Cosponsor: U of CA. Irvine Ctr. for Health Educ. Held at Kauai Surf Htl, Lihue, 06766. 3 days, 24 hrs.
- Apr. 15-21, 1979 Diving Med. U of H Schl of Med. 1960 E-W Rd., Honolulu 96822. Held at King Kamehameha, Kailua-Kona, HI. 6 days.
- Apr. 21-28, 1979 Emergency Med-1979 USC Sch. of Med. 2025 Zonal Ave. LA, CA 90033. Held at Royal Lahaina Htl., Maui. 5 days, 30 hrs.
- Apr. 21-28, 1979 Diagnostic & Therapeutic Skills in Internal Med., USC Sch of Med., Div. of Postgrad., 2023 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- Apr. May 18, 1979 Orthopedic Review, USC Sch of Med, Div of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- June 18-22, 1979 Comparative Psychotherapies, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina Htl, Maui. 5 days, 30 hrs.
- June 9-16, 1979 Radiology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Htl, Kamuela. 5 days, 30 hrs.
- June 23-30, 1979 Manipulative Med. USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Sheraton-Waikiki, Honolulu. 5 days, 30 hrs.
- Aug. 4-11, 1979 Ophthalmology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- Aug. 8-22, 1979 22nd Annual Postgrad Refresher Course, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Cosponsor: U of HI. Held: Honolulu, Maui & Kona. 39 hrs.
- Sept. 9-17, 1979 Practical Management of Anesthetic Problems, USC Sch of Med., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 31¼ hrs.

\*\*\*\*

## OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.

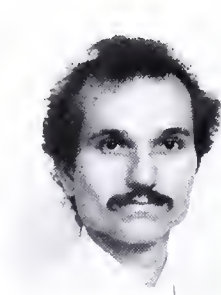
## ANNOUNCEMENT

January 12-18, 1980

15th International Surg. Congress—(10 Surg. Spec.) Cat. I—20 hrs. Held at Sheraton Waikiki, Honolulu, Creative Assoc. Chgo, IL. Contact: Pan Pac. Office—236 Alex Young Bldg. Honolulu or Charlotte (808) 536-4911.



## New Members



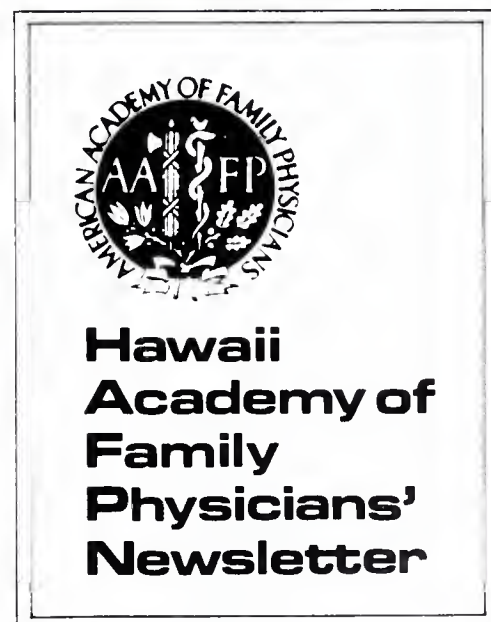
**David Evans, M.D.**

888 South King Street  
Honolulu, Hawaii 96813  
ACUTE CARE



**Paul K. Lewis, Jr., M.D.**

888 South King Street  
Honolulu, Hawaii 96813  
EMERGENCY ROOM



J. I. FREDERICK REPPUN, M.D.

**New Members—Howman Lam MD** is a new Active member and a transfer from the Georgia AFP; he received his MD from the UHSM first class in 1975 and has opened up an office in the Ala Moana Building. Welcome back to Hawaii!

**News of Members—Mary Glover and Pat Dietrich** are both elated over passing the ABFP examina-

tions. Congratulations, Gals! Pat was also a recent speaker at St. Andrews Priory. **Homer Benson** was elected to Life membership. **Varian Sloan** is "enjoying" his MI at QMC and has had so many colleagues sticking their heads in to wish him well that his Attending is getting worried. We're all happy in his recovery. **Felix Lafferty** was elected Pres-elect of the Honolulu County Medical Society and he has also been chosen by A.A.F.P. to be a member of the Ad Hoc Committee on Professional Liability. On the new Board of Governors of HCMS sit **Pat Walsh** and **Tom Cahill**, the latter as representative from HAFP *pro tem* until he is formally elected to the post by us at our annual meeting on 27 January 1979. **H.Q. Pang** will be honored at that meeting by the HAFP for his 50 years of Active Family Practice.

**Core Content Review**—1978-1979 reports that 17 members of our Chapter or 26.6% of our Active members are participating. We rate third in the nation, surpassed only by Connecticut AFP (30.3%) and Ohio AFP (31.2%). For this the coffers of HAFP were enriched by \$93.50, a ten per cent rebate of fees.

**The College of Family Physicians of Canada**—British Columbia Chapter, will co-sponsor a scientific session with HAFP in 1980, February 1 through 4, at the Hilton Hawaiian Village.

**Last Call**—this issue of the **HAWAII MEDICAL JOURNAL** may be out before our annual meeting on 27 January 79 and the "MINI-WORKSHOP in FAMILY & MARITAL THERAPY" by Noble H. Butler, Ph.D. from Northwestern University School of Medicine at the Mabel Smyth Auditorium on 27 and 28 January, from 9:00 to 12:00 and from 1:30 to 4:30 each day for a total of eleven hours of "P" credit. The annual meeting will take place in the Hilo Suite of the Main Tower at the Ilikai Hotel starting at 7:00 PM.

**CME**—The Martin Lichter Lectures in memoriam to a longtime member of HAFP, now deceased, will take place on 26 January. Unfortunately, notice of same arrived too late to be included in the last Newsletter, and too late for application for Category "P" AAFP credit. Famed cardiovascular surgeon Norman Shumway will speak at noon at Kam Auditorium and in the evening at Mabel Smyth. QMC announces its Second Annual Seminar on Acute Care on Saturday and Sunday 28 and 29 April 79. This one also is not categorized as "P."



## Clinical Pathologist's Easy Chair

FRANCIS FUKUNAGA, M.D.

## Colloid Osmotic Pressure (COP)

Osmolality determination is a measure of the solute particle concentration without regard to their size, weight or type. There are two categories of solute particles—the low molecular weight **crystalloids** (eg, sodium, glucose) and the high molecular weight **colloids** (eg, albumin). The crystalloids are, but the colloids are not, freely diffusible across semipermeable membranes. The crystalloids predominate overwhelmingly in plasma but the physiologic effect of the colloids is important despite their small numbers.

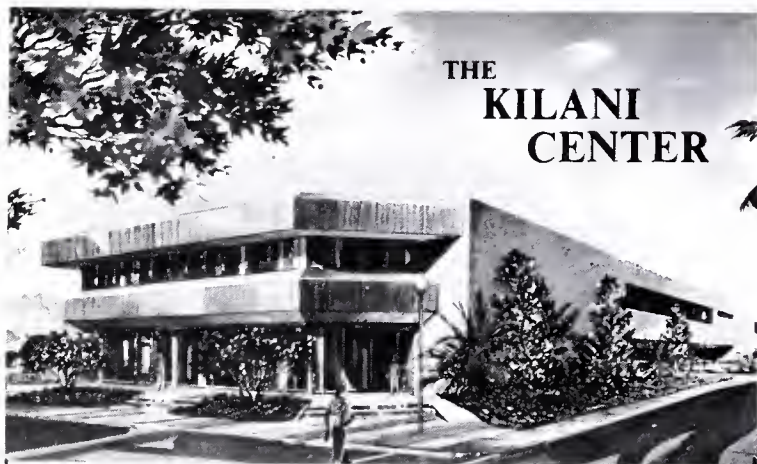
The standard osmometer cannot differentiate between crystalloids and colloids. Particle concentration is measured indirectly by their effect on freezing points or vapor pressure but the colloid osmometers measure colloid concentration directly. While **standard osmometry** is used to monitor water and electrolyte balance, low molecular weight intravenous therapy, renal function and drug intoxication, **Colloid osmometry** is used primarily to determine fluid and protein balance. COP is an excellent indicator of volume overload and aids in the evaluation of diuresis related to volume replacement and intravenous therapy.

### Increased colloid osmotic pressure may be due to:

1. IV induced diuresis.
2. Salt poor albumin therapy.
3. IV therapy with high molecular materials such as dextran.

### Decreased colloid osmotic pressure can be caused by:<sup>1</sup>

1. Major blood or plasma loss due to hemorrhage or inflammation.
2. Increased capillary permeability.



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3. Failure of liver to produce or mobilize plasma albumin.
4. Rapid infusion of intravenous crystalloid solutions to cause decreased plasma proteins.

Normal colloid osmotic pressure is  $25 \pm 2.5$  torr in ambulatory individuals and  $20.8 \pm 1$  torr when at bed rest.<sup>2</sup> The approximately 15% higher value when ambulatory is secondary to the decreased plasma volume associated with exercise. There is about a 10% fluctuation in each individual from day to day and there is a progressive decrease of COP with age. There is no significant difference between arterial and venous COP values. Hemolysis should be avoided since free hemoglobin will raise the COP. The sample may be refrigerated for seven days before testing but never frozen.

The most important use of colloid osmometry is the early detection of pulmonary edema. The transport of fluid across the pulmonary capillary membrane is directly influenced by the COP. The COP in the pulmonary capillary balances the effects of the pulmonary artery wedge pressure (PWP) + the tissue oncotic pressure + tissue hydrostatic pressure (which is positive in other tissues but negative in the lungs). The COP-PWP gradient (COP minus the PWP) is normally 8 to 12 torr.

**Pulmonary edema may be caused by one of the following:**

1. Increased pulmonary capillary permeability due to sepsis, pneumonia or burns.
2. Increased PWP with a net movement of fluid into the interstitial tissues. The PWP increase is usually the result of left ventricular failure following a myocardial infarction.
3. Decreased COP. The lower the COP, the greater the susceptibility to pulmonary edema.<sup>2</sup>

Pulmonary edema is due to the decrease of the COP-PWP gradient which may be due to an increase of the PWP following a myocardial infarction and/or a decreased COP due to decreased albumin. The COP-PWP gradient is markedly depressed in either cardiogenic and noncardiogenic pulmonary edema. The cause in cardiogenic edema is an increased PWP while in noncardiogenic pulmonary edema, it is secondary to a decreased COP. A COP-PWP gradient of less than 4 torr is always associated with pulmonary edema.<sup>3</sup> Reversal of the pulmonary edema with digoxin and furosemide is closely related to a concomitant change in the COP-PWP gradient.<sup>4</sup>

COP correlates with prognosis.<sup>5</sup> Patients usually do not survive when the COP is less than 12.5 torr and none survive when it is less than 10.0 torr. COP of over 17 torr is a safe level and 11 to 16 are borderline values.

COP measurement may be required in patients in cardiac and respiratory care units, post-op care units and in the emergency room. COP measurement is also useful in monitoring albumin therapy since albumin accounts for 80% of the total value.

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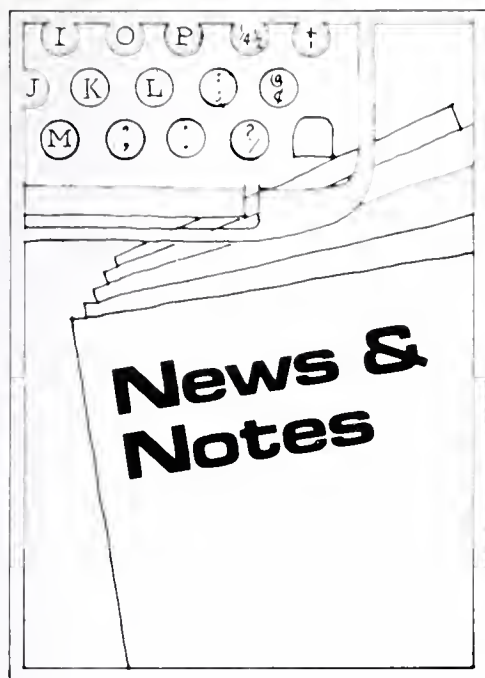
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HENRY N. YOKOYAMA, M.D.

## Professional Moves

The tumultuous Year of the Horse has come to an end . . . except for the month of December, wherein we still have a few announcements to polish off . . . **Warren Wong** turned solo and moved to the Queen's Physicians' Office Building; OB man **Glenn Hayashi** moved to suite 410, Professional Center Building; another OB man, **Elbert Tomai**, joined the Central Medical Clinic, Inc. at 1481 So. King St.; and urologist **Thomas Ito** relocated to 1171 So. King Street (The Yamamoto Medical Building). On the Big Island, internist **Alan "Sammy" de Silva** opened at 319 Kinoole Street and in Kona, **Edgar Haunz** resumed his practice with the Kona Medical Group Inc. On Kauai, psychiatrist **Emily Khaw** opened her office at the Wilcox Memorial Hospital, Lihue.

Now we can greet the Year of the Sheep, a more placid and quiet year, we hope . . . In January, **George Druger**, Diplomate of the American Board of Internal Medicine and Pulmonary Diseases, opened his office at the Queen's Physicians' Office Bldg.; internist **Richard Lau** joined the Medical Specialty Clinic in the American Security Bank Bldg. . . . On Maui, **M. Mirzai** and **H. Aquilizan** opened at 1939 Vineyard St., Wailuku; and surgeon **Sakae Uehara** relocated his solo office to 1827 Wells Street, Wailuku . . . On the Big Island, OB man **Robert Aikman** joined the Hilo Medical Group, Inc. at 1292 Waiianuenue Ave., Hilo; and Hilo Medical Group cardiologist **Djon Indra** became **Djon Indra Lim** effective Feb 1 . . .

**Eugene Magnier**, who limits his practice to cardiovascular diseases, opened his office in the Aiea Medical Bldg. and **Barnett Seemore Salzman**, fellow of the Royal Society of Health, "joyfully announced" the opening of his practice of "New Age Psychiatry" at 931 University Ave.

## 1979, The Year of the Ram

If you were born in 1907, 1919, 1931, 1943, 1955, 1967, or 1979 you are a ram—or sheep—person . . .

Sheep people are elegant, highly accomplished in the arts, and passionate by nature. But they are also shy, pessimistic, puzzled about life and uncertain about the direction they should take. Sheep people are deeply religious and timid by nature and are not world conquerors or leaders. They are passionate in whatever they do and whatever they believe in. Because they are uncertain about themselves, sheep people must be guided and they do best at the arts. They are wise and gentle in their ways and are easily stimulated to pity for those who are unfortunate, and would help the unfortunate expecting no thanks and not wanting any. In fact, they would be

embarrassed to receive thanks. People born in the Sheep Year will have love and emotional problems during the second phase of their life, but during the third phase, they will have extreme good fortune.

## Hors De Combat (Part I)

We are including the following letter by our Editor and an editorial by our Associate Editor from our November issue for the edification of those who may have missed them:

Arnold to Califano

Nov. 1, 1978

Joseph Califano  
Dept. of HEW  
Washington, D.C.

Dear Mr Califano:

In the HEW pamphlet urging second opinions in regard to the need for surgery, the middle paragraph on Page 5 says:

"If, as a result of the second opinion, you decide not to have surgery, you avoid the risks, costs and discomfort usually associated with surgery."

I gagged on this choice morsel of bureaucratic oversell. What about adding:

"Of course, you also miss out on the benefits of such surgery, if it happens the first doctor was right and the second doctor was wrong."

How does HEW propose to avoid being pushed into the position of advising a third opinion, in the event the first two are different? How can HEW conscientiously avoid sharing—indeed, bearing a major share of—responsibility for second opinions which end disastrously?

In one man's opinion, you have overstepped the bounds of ethics, propriety, and good sense, in promulgating and disseminating this pamphlet. We propose to say so editorially.

Sincerely,  
HARRY ARNOLD JR., M.D.  
Editor

### Second, Third, Fourth and Fifth Opinions

Above is a letter: *Arnold to Califano*, that needed to be written. The subject: DHEW's pitch in a brochure for a second opinion in surgery.

DHEW has put itself in the position of a meddling aunt, uncle or in-law, who takes the baby to a "specialist" in "turned stomachs"—a lay-person who massages the abdomen until the hot appendix ruptures.

Physicians ordinarily are quick to recommend a consultant when the problem is real and the outcome in doubt. Physicians, for the most part, are ahead of the patient and they sense when the latter is about to ask for one anyway. Since medicine is more of an art than a science, the rapport between patient and doctor, the trust a patient puts in his personal physician, becomes a large factor in therapy.

Even though to seek consultation may seem to be an admission of perplexity or a doubt in his own capability on the part of a physician, it is only right and proper for him to share it with his intelligent patient: as partners in problem-solving, both agree to this step in a decision-making process. On the other hand, many a patient needs, and would rather have, the support of a firm and confident doctor. Each instance is its own special case. Califano would change all this and "regulate" it by cold, cut-and-dried, impersonal methods.

We need to remind HEW that we already have a system going, particularly in-hospital that is conducive to consultation, and even to multiple opinions and team care.

For the government to step in, and by law or regulation to mandate second, third and fourth opinions in surgery, is to destroy the basic trust and the close personal relationship between patient and doctor that is so essential to quality medical/surgical care.

The intent of the Feds is obvious: "Don't let them operate: it will save money." Carry it one step further, Mr. Califano: "No more CPR; let them all die: it will save money."

However, there is an underlying principle that most people fail to see. That is: "He who pays the bills has the right to call the shots." We are getting a foretaste of how it will be under National Health Insurance. In Workmen's Comp, for example, the employer has the inherent and legal right to have the injured employee, who is claiming a disability, examined by a company-appointed physician. In fact, there are MD specialists now who spend nearly all of their time at this. They have become notorious for being "patient haters;" their total loyalty is to those who pay: the employer or the third party payor. And, please remember that the biggest third party payor of all is the federal government.

Beware, Califano! You are pushing so hard—in the name of cost control—for denial of benefits to the people, that you may find yourself in Nero's sandals—fiddling, while Washington burns!

J.I. FREDERICK REPPUN, M.D.  
Associate Editor

## Life In These Parts

Preliminary studies from two ongoing studies on smoking in Hawaii seem to indicate the following: One-pack-a-day smokers in Hawaii are twice as prone to heart attacks as non-smokers . . . Two packs a day triples the risk . . . Caucasians smoke more than other ethnic groups in Hawaii with Hawaiians and part-Hawaiians second . . . Yet Hawaiians and part-Hawaiians have a higher incidence of lung cancer than Caucasians . . .

The Hawaii Heart Study has followed 8,000 men of Japanese ancestry aged 45 to 69 since 1965. Associate director **Katsuhiko Yano** reports that all 8,000 men were free of heart disease when first examined 13 years ago, and that cigarette smoking has turned out to be a most important factor, along with high blood pressure and high serum cholesterol. Six-year follow-up statistics show that men smoking a pack a day had a 50% higher incidence of coronary disease and twice as many heart attacks as non-smokers, while two packers had three times that of non-smokers.

A 1970 study in process directed by **M. Ward Hinds** of the Cancer Center of Hawaii shows that Caucasians smoke the most of any ethnic group. Hawaiians and part-Hawaiians are the second heaviest smokers but had more lung cancer than Caucasians. Of Hawaiian men and Japanese men smoking the same amount, Hawaiian men had twice the lung cancer incidence of Japanese men . . . Among teen-agers (15 to 19) interviewed, the study showed: Caucasian men: 51%, women: 47%; Hawaiian men: 33%, women: 39%; Filipino men: 33%, women: 26%; Japanese men: 25%, women: 15%. The Chinese smoked the least.

The State's Medicaid Fraud Control Unit successfully prosecuted its first case in January when three Maui pharmacists pleaded guilty to first degree theft. They were charged with having defrauded the government of more than \$20,000 in a two-year period . . . HEW officials estimate that improper payments in 1977 alone cost American taxpayers more than \$2 billion . . .

Kaiser internist **Marsha Mark** reported at the Kaiser 10th annual CME symposium that last year, two persons died and at least 80 others were severely ill from overdoses of acetaminophen, more commonly known as Tylenol. Most of the cases were attempted suicides who took huge doses . . . **Rea Chittenden**, medical consultant to the Poison Control Center at Kapiolani-Children's Medical Center, reported that American doctors have been slow to recognize the toxicity of acetaminophen which he feels "is twice as toxic as aspirin" . . . "There is an antidote to acetaminophen, but it has the disadvantage of being an FDA-controlled, investigational drug," Rea said . . .

"Hawaii's **Dr. Norman Goldstein** won raves from colleagues (and the press) in San Francisco during the American Academy of Dermatology Convention. His exhibit, 'The World of Tattoos,' drew big crowds to view his video program on tattoo removal techniques and to eyeball his vast slide collection of remarkable tattoos." (Daacon Dec. 13) "When Kaiser's **Dr. Bob Oldt** says he's going home to his 'old bag,' he's not talking about wife Sue—Bob works out on a full-length punching bag that hangs in his living room like a chandelier." (Daacon Dec. 10)

Hilo Hospital anesthesiologist **Richard Lundborg** was chosen honorary chairman of January 27's "Superkids" competition conducted by the American Lung Association of Hawaii. . . . "Superkids" is a mini-decathlon for boys and girls seven through 12, measuring their speed, jumping and agility in the 40-yard dash, standing long jump and potato sack race at the Honolulu Tennis Stadium.

**Robert Melton**, Kauai District health officer, feels that a 64-year-old Kauai man may have died from leptospirosis which he contracted while swimming in the Kalihiwai River. Robert reported that there have been three cases of leptospirosis reported on Kauai in 1978 and the victims are people who had not grown up in rural Kauai, which indicates a lack of resistance to the spirochete.

The Voluntary Cost Containment Committee reported a 13% increase in Hawaii's hospital costs for the first 9 months of 1978, which is well under the 20% jump for the same period last year. Meanwhile, the rest of the nation's hospitals assailed a federal plan to limit their cost increases to 9.7 percent this year . . . An American Hospital Association spokesman, J. Alexander McMahon, reported, "Our voluntary effort is working. It's cutting the rate of increase in our costs . . . But HEW Secretary Califano's vague 9.7 percent proposal will absolutely endanger our efforts to adequately care for patients" . . . AMA Executive VP James Sammons snapped, "That 9.7 percent is a hip shot, a seat-of-the-pants figure that Mr. Califano has come up with. To set such a figure for an industry which serves the health of 212 million Americans is sure to result in a rationing of health care."

Nine months ago, thoracic surgeon **Judd McNamara** suggested that the Queen's Medical Executive Committee pass a resolution opposing the sale of cigarettes at the hospital. His fellow doctors kicked it around for a couple of months, passed it with a comfortable margin and sent the resolution to the hospital board of directors which agreed.

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But then the board reversed its decision when the gift shop and others objected strongly to the prohibition. Judd says, "I think the board didn't take it very seriously. . . . We're in an era when preventive medicine is a kind of a catch phrase and we're trying to decrease hospital costs, too. But it almost looks like the board is trying to create more disease to assure that the beds are filled!" **Will Henderson**, executive director of QMC, defended the board action: "People brought to the board's attention that there are many who smoke and that it was creating a great inconvenience to patients in the hospital now that they were no longer able to get cigarettes." Will did not think that "it was a case of the directors being easily led from tobacco road to the primrose path and back again. . . . The major emphasis came from other people who said 'I feel I have a right to smoke and this only creates a feeling of antagonism in me toward your organization.'"

"As **Dr. Fred Shepard's** 25-year dream of a full-fledged Rehabilitation Hospital of the Pacific came true Friday, he gave three reasons for keeping his speech short: 1) The danger of being overcome by emotion; 2) his tendency to talk non-stop when speaking extemporaneously; and 3) the fact that the zipper on his pants was stuck in the open position. Said Shepard, 'If you don't think that's disconcerting. . . . Modesty was saved by a safety pin. . . .' (Dave Donnelly's Hawaii—Dec. 18)

## Variations on a Theme of Murphy's Law:

(Contributed by Henry Oyama for the latest issue of the Pac PSRO Newsletter)

Murphy's Law: Anything that can go wrong will go wrong. . . .

"When everything is going well, you have obviously overlooked something. . . . When things go wrong, it goes wrong at the worst possible time. . . ."

"When there is a possibility of something going wrong, the one that does the most damage will go wrong. . . ."

"Nature always sides with the hidden flaw. . . ."

"The longer you fool around with anything, the greater the chance of screwing it up."

"Once you screw it up, any effort to improve it will make it worse. . . ."

"No good deed goes unpunished. . . ."

## Hors De Combat (Part II)

"The chap who's been springing up all over town dressed in a Superman outfit? Turns out he is a psychiatrist, **Dr. Barnett Salzman**, and his behavior is peevish colleagues. So why does he continue to ride around on his moped, visit post offices and restaurants dressed as Superman? 'I am an artist when I dress,' says Barnett. 'I'm revealing some of my creativity in the streets. . . . it shows patients everybody is a superman.'" (Dacon Dec. 22)

Excerpts from the *Advertiser* editorial of Dec. 17: "A Federal Trade Commission administrative judge has told the doctors' powerful lobbying and professional guild that its code of ethics may no longer prohibit advertising. . . . The judge said, 'Rules that prevent advertising, soliciting business and signing agreements to provide certain health care services amount to a conspiracy that results in higher medical bills and poorer service.' . . . Doctors are unlikely to rush to advertise or fight price wars even after challenges to this new ruling are over. . . . Most doctors seem to be able to get enough patients already. And most people do not choose a physician by price but on a word-of-mouth reputation for skill and proficiency. . . . The ruling is a sound one and long overdue. To argue that physicians advertising might lead to widespread abuses is to argue that the vast majority of American doctors are not competent, dedicated and honest. We believe they are. . . . Still the new freedom may lead to a few abuses. As in the past, the AMA will have to devote its efforts to uphold-

ing high standards. And it may soon need a mechanism for checking on deceptive advertising rather than barring advertising altogether." (Ed: Good thinking!)

An 18-year-old Wahiawa woman won a \$21,000 judgment from the federal government after a non-jury trial in federal court of medical malpractice against several Tripler doctors. Judge Dick Yin Wong ruled 6 days before he died on Dec. 26 that the hospital was negligent in allowing an intern, assisted by a resident to perform plastic surgery on a Melissa Roper. In 1974, when surgery was done to correct a scar on Melissa's right knee, infection set in and a worse scar resulted. The mother and daughter had assumed that the board certified plastic surgeon they had met earlier in the hospital would operate. Judge Wong ruled that the hospital failed to obtain the proper informed consent of the plaintiffs by not telling them the level of training of the operating surgeon. . . .

In December the AMA House of Delegates, by more than a 2 to 1 margin vetoed a proposal by the board of trustees to submit a comprehensive national health plan bill to the next session of Congress. The delegates felt that the board should instead recommend modifications to the present health care system. The opposition to the national health plan arose when delegates argued that the federal debt and inflationary spiral do not provide a proper climate for sponsoring the program which the AMA had promoted since 1970.

HEW Secretary Joseph Califano asked hospitals to accept a voluntary goal of 9.7% for the average rate of increase in total hospital expenses, nationwide for the calendar year 1979. The proposed goal refers to expenses rather than charges because most hospital bills are based on cost reimbursement. . . . Joseph also announced a second voluntary goal to limit capital expenditures by hospitals for projects and equipment costing more than \$150,000 to a total of \$3 billion, this sum to be apportioned among states according to past capital expenditures. Joe feels that the voluntary limits are reasonable and would save Americans and the economy as a whole, \$69.5 billion in total hospital operating expenses over the next 6 years. An American Hospital Association spokes-



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PERSONNEL-ITY OF THE PACIFIC

January 9, 1979

Dear Doctor:

Personnel-ity Of The Pacific announces a reorganization and change in operation to a completely Employer-Paid-Personnel Consultant Agency.

Lanny K. Williams is assuming management of the Temporary Placement Division. Paul S. Isenburg, Ph.D., Director of Medical Services, assumes additional responsibility for the Permanent Placement Division.

With their depth of experience and broad resources in both the temporary and permanent fields, they will continue and expand the professional services to existing and prospective clients.

With this change in management, Personnel-ity Of The Pacific will offer expanded and extensive services in recruiting, advertising, screening, testing and reference checks.

The management team has taken steps to allow greater flexibility for the benefit of employers in the community.

Please contact us for your personnel needs.

Sincerely,

*Paul S. Isenburg*

Paul S. Isenburg, Ph.D.  
Medical Director

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686

man said the guidelines are “unnecessary, unworkable and would undermine the health industry’s successful anti-inflation program, and we view them as a move toward federal control instead of a voluntary program.” The Hospital association has been conducting its own voluntary cost containment program since 1977 . . . **George Mills**, chairman of the Voluntary Cost Containment Committee in Hawaii said, “He is unrealistic in what he is saying.” Hawaii’s hospital costs were about 13% over 1977, but George feels that “it might have been closer to 17 or 18% if the voluntary effort had not begun . . . Our voluntary program has received national recognition. It’s probably one of the most effective in the country. We have a tremendous responsibility to the citizens not to jeopardize the quality of hospital care,” Mills cautioned.

A committee of the state legislature heard **Mark Sperry**, administrator of the Henriques Medical Center in Waimea suggest that the Kohala and Honokaa hospitals be converted to longterm care facilities and that the Henriques Medical Center be made the sole acute care hospital for the northern part of the Big Island . . .

**Charles Mitchell**, chairman of the Emergency Medicine Dept. of Maui Memorial Hospital says the community should vigorously oppose any attempt to establish a detox program on Maui for heroin addicts. The DOH had already negotiated a contract with Aloha House on Maui for the program and the Review Committee of the Tri-Isle Health Planning Council was just now being asked for its recommendation. Charles said, “We are not unsympathetic to people who have hard drug habits, but who in their right minds would want to generate a problem on Maui that does not exist? If we allow a de-tox center here, we might as well put a want ad in all the major newspapers advertising a new resort for drug addicts . . . In an attempt to do good, we may precipitate a disaster . . .”

## Elected, Appointed, & Honored

Our congratulations to **Walter W.Y. Chang** who was recently installed president of the HCMS. Other society officers are **Felix Lafferty**, president-elect, **Calvin Kam**, Secretary and **Henry Fong**, treasurer. Board members are **Vincent Aoki**, **Thomas Cahil**, **Bernard Fong**, **Henry Fong**, **Norman Goldstein**, **George Kimata**, **Masaru Koike**, **Felix Lafferty**, **Thomas Lau**, **Michael McCabe**, **Michael Okihira**, **Douglas Ostman**, **Marco Rizzo**, **Alfred Scottolini**, **Walton Shim**, **Myron Shirasu**, **Robert Thune**, **Thomas Walinski**, **Patrick Walsh**, **Neal Winn**, **Henry Yim** and **Henry Yokoyama**.

**Cesar de Jesus**, urologist, is the new president of the Philippine Medical Association of Hawaii. Other officers of this medical group are **Quintin Uy** and **Fortunato Elizaga**, vice presidents, **Romeo Pineda**, secretary, **Etty Bautista**, treasurer and **Ignacio Torres** and **Arturo Salcedo**, board members.

**Harold Kushi**, with the Maui Medical Service in Kahului, Maui will chair the \$10,000 fund drive for the J. Walter Cameron Center. The fund money will be used to expand the Cameron Center and to help staff the Multi-Media Center and to assist the Kokua Service. Harold is an old hand at chairing drives, having previously served in fund drives for Ka Lima O Maui and the junior golf program . . .

## Sportsmen

We learned from Jack Wyatt’s column, *The Outdoors* that **Paul Ryan**, 33, now in his residency, was a lousy basketball coach and that in short and middle distance running, his times were not earth-shaking. But Paul, who taught at the Big Island’s Hawaii Prep Academy, started to run 100 to 120 miles a week in the hills of Waimea and Kohala. In the past 3 years Paul has logged six 26.2-mile marathons, three 50-miles races, one 100-kilometer and one 100-mile race and a host of shorter events. Ryan admits that the marathon is not his best distance . . . “I much prefer the longer races. In my training for ultra-marathons, I sometimes run a marathon-distance on four successive days.”

From Beverly Creamer’s article, “It’s M-Day: race to end all races” we learned that HMA (Honolulu Marathon Association) president **Jack Scaff** reported that “it was the largest field of women ever massed anywhere for a long distance race . . . There were 1,400 of them.” We also learned that **Jerry Tucker** is in charge of aid stations and says, “He (referring to Jack) says it will double and we all think he’s crazy . . . You know what he’s saying for next year? Ten to 12 thousand.” Jerry’s forte is the icy sponge and he managed to get 6,000 perfect palm-sized ones for the delight of the runners. The sponges are dispersed to the aid stations and given to the runners along with water and specially diluted, defizzed Coke supplied free by the Coca Cola Co. “If it weren’t for the assistance of community organizations manning the aid stations, numerous companies lending or donating supplies, and many other individuals taking care of hundreds of other chores—about 1,000 volunteers—the marathon wouldn’t be possible,” says Tucker.

“Most seemed unconcerned about who had won except for Dr. Jack Scaff, the runner’s guru, who trotted by at 3:33. ‘Who won?’ he asked and learned for the first time that **Don Kardong** had pulled it off over an hour earlier . . . Scaff preaches a rigorous—some would say dogmatic—regimen over a period of months before the event . . .” (Dave Donnelly’s Hawaii)

## Golfers

Intrepid golfer **Mike Okihira** was hurrying a bit in his Honda Accord on Thursday afternoon in December when he was ticketed for speeding on the Pali Hwy. and reached Mid Pac CC a bit late for the starting time. Undaunted, he shot flawless golf for a gross 75 and won the low net jackpot for the day. In November Mike, who carries a 5 handicap, shot two net 66’s to win the Thursday Club Presidential Trophy which was retired since he had won it for the third time.

## HMCS Gold Tournament

The first Annual HCMS Golf Tournament was launched successfully by Chairman **William Dang** and held on Nov. 29 at the Hawaii Kai Course with 43 entrants. When the dust had settled, the winners of the men’s flight were as follows: 1st Place: **Bill Dang** with net 65 (82-17-65); 2nd place **Ed Kagi-hara** also with net 65 (86-21-65); 3rd Place: **Alvin Perez** with net 66 (79-13-66); 4th Place: **Glenn Kokame** with net 67 (78-11-67) (Glenn also won low gross with his 78); 5th Place: **C.M. Lum** with net 79; and 6th Place: **Catalino Cachero** with net 80. The women’s flight winner was **Librada Mercado** with a net 67. Guest flight winner: **Andy Saranchock** with a net 72.

## Tennis

First annual HCMS Tennis Tournament was held on Nov. 26, Sunday at Pay Less Courts with pick up doubles teams participating. Co-chairmen: **Ken Kern** and **Dennis Maehara** . . . First Place: The team of **Yutaka Yoshida** and **Jordon Popper**; 2nd Place: **Henry Yim** and son; 3rd Place: **Ben Chang** and **Walter Watt**. Mixed doubles winners: **Alex** and **Colleen Roth** . . .

## Go—Japanese Chess

Surgeon **Kazushi Tanaka** who holds a 5th rank in Go recently won the all state open championships.

## Marathoners

**Cora Au**, who admits to having never done anything athletic before, finished in her first marathon endeavor in 6 hrs. 17 min and 4 sec. . . . Cora bubbled, “Now I understand why Francis (her husband) watches sports on TV for hours on end . . . I’ve never been a sports fan before because I’ve never gotten involved in athletics before . . . It’s so thrilling . . .”



Our new president of the Mid Pac Thursday Club, Eddie Emura, also ran his first marathon with a bum knee and finished in 5 hours . . .

## Bulletins

The nation's largest lung cancer screening program funded by the National Cancer Institute and conducted at the Mayo Clinic, the Sloan Kettering Cancer Center in New York City and the Johns Hopkins University Medical School has failed to turn up any evidence that death rate from the disease is affected by early detection and treatment. At Mayo, 10,000 volunteers were divided into two groups, one received chest Xrays and sputum cytology exams every 4 months and the others received the tests on entering the program and thereafter annual reminders. The two groups showed no significant difference in total lung cancer deaths. At Johns Hopkins, the volunteers were men over 45 and at least a pack a day smoker. The lung cancer cases ranged from 3.7 per 1,000 at Johns Hopkins and Sloan Kettering to about 4.5 per 1,000 at Mayo.

Ralph Nader's Health Research Group reported that doctors prescribing oral drugs for nearly 2 million diabetics may be guilty of malpractice . . . About 1.75 million diabetics have stopped using the oral drugs because of the controversy, but nearly 2 million still take them. Sidney Wolfe, director of the Nader group told James Sammons, executive director of AMA that he should urge AMA members "not to prescribe these drugs to the large numbers of overweight diabetics for whom such therapy represents malpractice." Wolfe and other critics have contended that proper diet and weight loss are better therapy for diabetics than the oral drugs. An Upjohn Co. spokesman said Wolfe's charges represent just another outcry by the consumer advocate in the face of a nine-year old medical controversy. "Wolfe's allegations are based on a study that is 'flawed and indeterminate.'"

## Osler's Aphorisms . . .

Alter the golden rule—what you do not like when done to yourself, do not do to others . . .

Consider the virtues of taciturnity. Speak only when you have something to say . . .

They physician needs a clear head and a kind heart . . .

Save the fleeting minute; learn gracefully to dodge the bore . . .

The greater the ignorance, the greater the dogmatism . . .

Medicine is a science of uncertainty and an art of probability . . .

Look wise, say nothing, and grunt. Speech was given to conceal thought . . .

Advice is sought to confirm a position already taken . . .

## Physicians Speak Up

**Fred Reppun**, our favorite social critic, wrote to the editor: "I recently paid \$31 for the rental of a deposit box at the First Hawaiian Bank. This is an increase of \$6 or 20.4 percent over last year. At a time when the US is faced with the ravages of rampant inflation, it is indeed sad to witness one of our foremost financial institutions in Hawaii imposing such an example of total disregard for President Carter's urging on a voluntary basis, a curtailment of wage and price increases . . . This may be a small matter—I cannot see where the continued existence of a metal box that has served me for about 20 years and that requires no maintenance warrants this drastic jump in rental—but it is significant. Banks, above all, should be in the forefront of the fight against inflation. I would expect the nation's banks to exert pressure on the Federal Reserve Board to keep the federal government's monetary policies in greater check."

We caught this letter to the editor by gastroenterologist **Gerald Hiatt**: "I doubt that anybody can claim to be a more ardent advocate of free enterprise than myself, but none the less, a comment is in order in regard to Mr. Peter Wagner's recent articles covering colonic irrigations, massages, and health spas. The articles imply and also state outright certain benefits that are supposedly known to accompany the above procedures, when, in fact there is absolutely no scientific basis to support any of the claims made . . . As a physician, it would be unethical for me to make any such claim without scientific proof, and I feel News Editors should abide by the same standards. Perhaps the word "alleged" should be used a little more often?"

**Fred Reppun** took issue with the Star Bulletin editorial, "Environmentalism and the Economy" which castigated Life of the Land for being two faced: On the one side being violently environmentalist, and on the other trying to bridge the gap between its viewpoint and that of the CILO (CONSTRUCTION INDUSTRY LEGISLATIVE ORGANIZATION).

"There is no doubt whatsoever that Life of the Land is dedicated to the proposition that the people and the environment need protection against rapacious developers and builders, especially on an Island as small and as crowded as ours has become. That Life of the Land made overtures to its opponents and promoted a dialogue is to its credit—a gesture towards letting the audience, the people, have its say. The CILO, on the other hand, by boycotting that recent conference, suggested that it could not win in a debate and, therefore, didn't want to play." Fred added maliciously, "A good thing that our glorious Rainbow football team didn't feel that way about the USC Trojans!"

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not the SHPDA. (And to think that we are *paying* for all this foolishness!)

The only Federal bureau the physicians should have had to fool with, of course, was the Post Office. I asked why they didn't just move, and ignore the clowns; they considered it, they told me, until threatened with a fine of \$500 per day. Think of it!

But the worst is yet to come: There's talk of expanding this whole circus to review all physician relocations and major office expenditures. The philosophy seems to be that if the Bureau can spend a dollar to save a nickel, and keep a lot of nice folks busy meeting and stapling, it's a worthwhile enterprise.

Heaven help us!

JOHN M. CORBOY, M.D.

193 Halai St.

Hilo, Hawaii

December 31, 1978

Editor, HMA Journal

320 Ward St.

Honolulu, Hawaii

Dear Sir:

The "latest Polish jokes" on page 411 of the December issue are excellent illustrations of why many consider the HMA Journal a 3rd rate publication. They are not only humorless and in poor taste, but are also of a bigoted caliber, surely not worthy of even the pulp publications.

Is there any wonder why I should reconsider my membership?

A. STEPHEN WOO, JR. M.D.

A. Stephen Woo, Jr., M.D.

193 Halai St

Hilo

Dear Dr. Woo:

Your protest regarding the 3 jokes on page 411 of our December issue reminded me of the story about the lady who asked Bess Truman if she wouldn't try to persuade her husband, the president, to stop using the word "manure" in public, and say "fertilizer" instead. "My dear," replied Mrs. Truman, "you have no idea how much trouble it was to persuade him to say 'manure.'"

I share to the full your distaste for ethnically slanted jokes, Polish or any other, unless told by a member of the victimized class, which is not the case here. Nevertheless, I must point out that Dr. Yokoyama is not by any stretch of the imagination a bigot; and the Poles themselves make jokes of exactly this kind, and so too do the Jews, and the Italians, and the haoles; you really cannot base a case for a charge of bigotry on the telling of such jokes. I agree with you it wasn't funny; nor was the second one (also with an unfortunate racial overtone); and the third one was simply a statement of historical fact, which has been fully documented in a published book entitled "Flushed with Pride."

You ask whether it is any wonder why you should reconsider your membership; and I can only reply in all sincerity that it surely is. Disapproval of three trifling "jokes" which escaped the blue pencil seems to me a tenuous and trivial reason indeed for abandoning your support of so valuable an institution as your county or state medical society. I hope you won't resign, and in any case I will discuss this problem with Dr. Yokoyama and we will try to offend your sense of the fitness of things less often and less severely in the future.

Thank you for writing, and not just brooding! Your candor does you credit!

Sincerely,

HARRY L. ARNOLD JR. M.D. *Editor,*  
HAWAII MEDICAL JOURNAL



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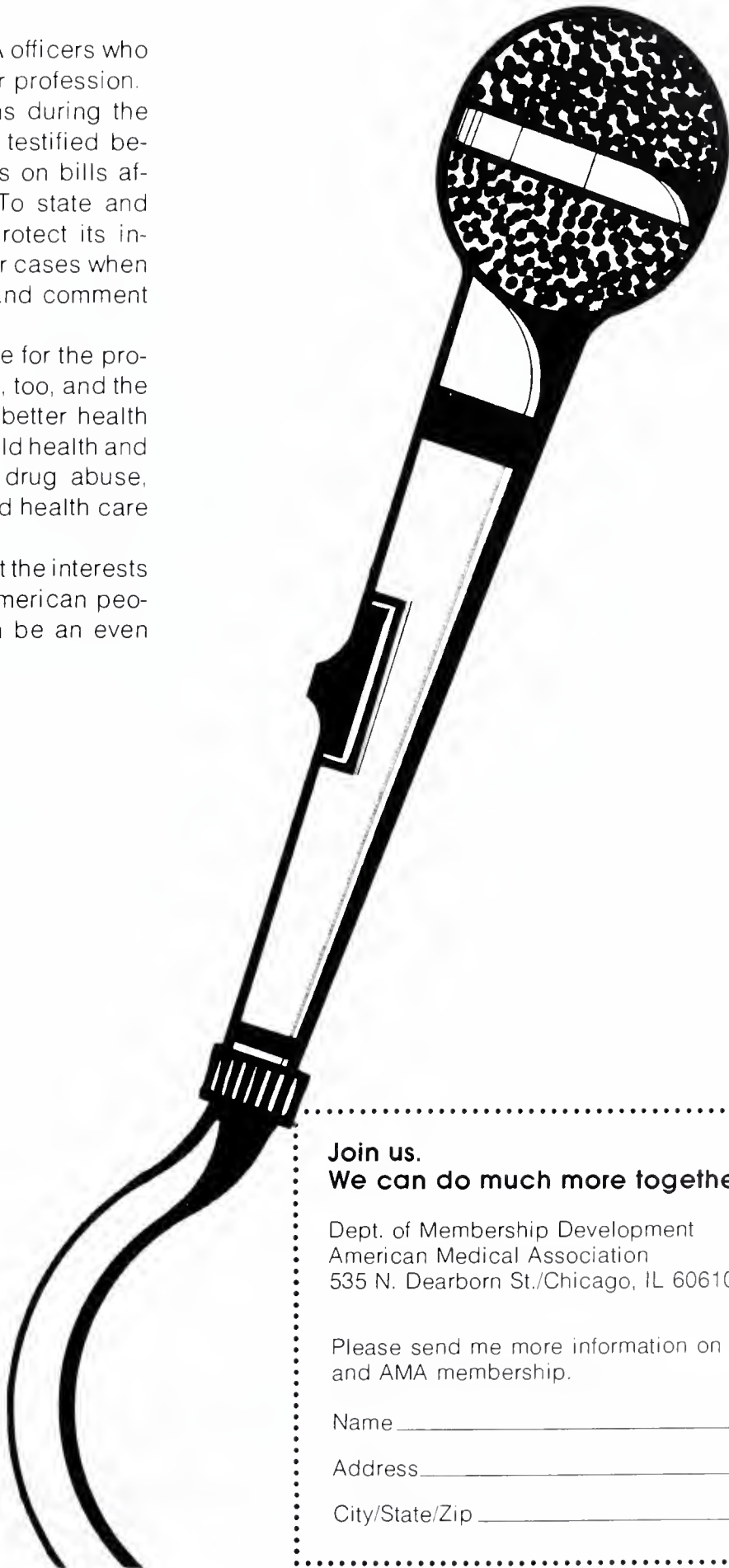
**"Mr. Chairman,  
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... Dr. Beddingfield ... Dr...."**

These were but a few of the many AMA officers who have gone to the Hill to represent our profession.

On more than two dozen occasions during the 94th Congress, AMA representatives testified before Congressional health committees on bills affecting the delivery of health care. To state and explain our profession's views. To protect its interests. In addition, there were 72 other cases when the AMA submitted written analysis and comment on legislation.

But the AMA isn't solely an advocate for the profession. It's an advocate for the public, too, and the passage of legislation for more and better health care. Legislation such as maternal, child health and crippled children services. Alcohol, drug abuse, and mental health programs. Improved health care for American Indians.

The AMA goes to the Hill to represent the interests of the American physician and the American people. With your support, the AMA can be an even more effective spokesman.



**Join us.  
We can do much more together.**

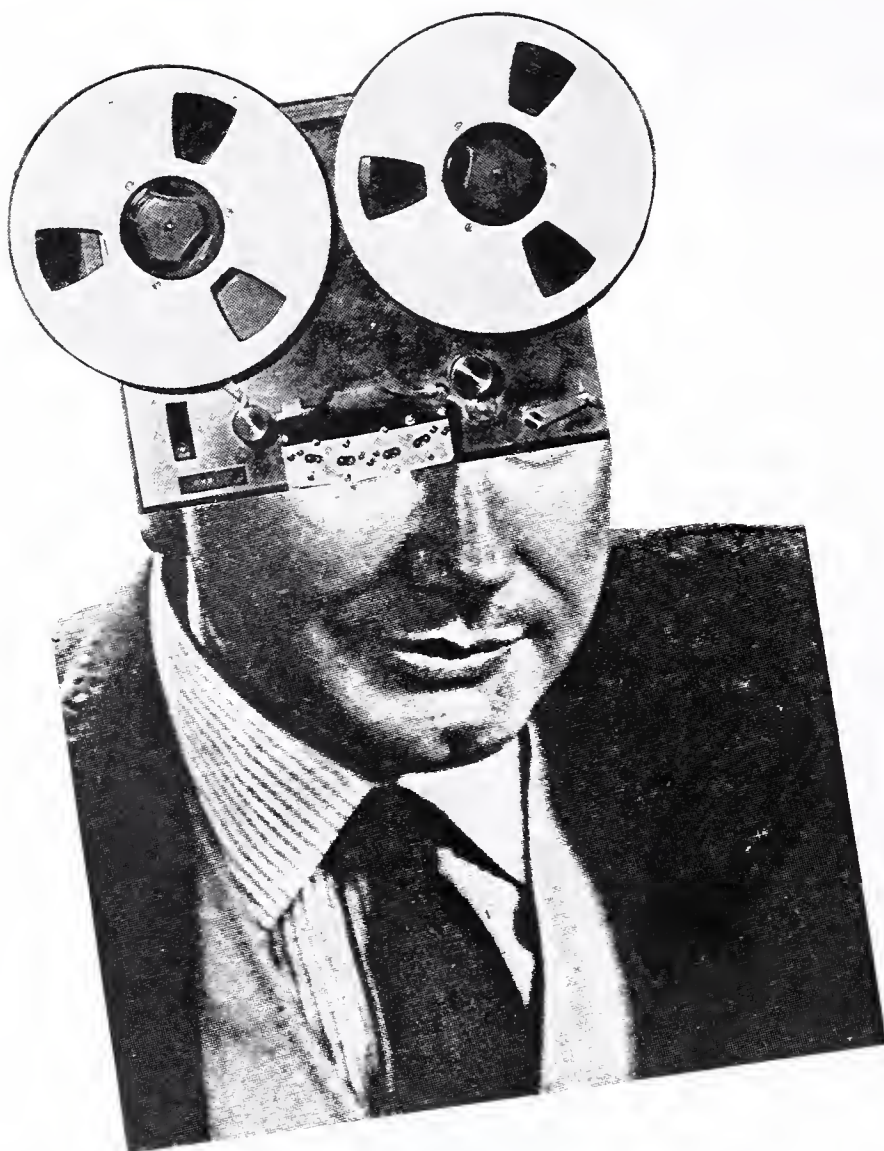
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FEBRUARY, 1979  
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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma. May be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,  
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**Reference:** Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.



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# Melanomas, A Caucasian Problem?

SAMUEL D. ALLISON, M.D., M.P.H.,\* *and*  
THOMAS A. BURCH, M.D., M.P.H.,\*\* *Honolulu*

In 1957 one of the authors (S.A.), with the aid of other practicing dermatologists in Hawaii, determined that there was about a 45 to 1 differential rate in the occurrence of skin cancer among Caucasians as compared with Orientals.<sup>1</sup> Epitheliomas do occur in Orientals, but are relatively rare.

In contrast to epitheliomas, nevi and seborrheic keratoses abound in Orientals, and most of these lesions are black. With all that is being written about the dangers of black lesions in the American press, clinically it has been found that many Orientals are quite alarmed about their lesions, believing they may be of great potential danger.

A study of deaths from malignant melanomas could serve two major purposes. If the death rate were much less in Orientals than in Caucasians, it would allay fears in our population with genetically black nevi and keratoses. If death rates were found to be similar in these groups, it would alert physicians to the need for more meticulous discrimination between innocent and potentially dangerous lesions in all racial groups.

A study of causes of death, rather than diagnosis of melanomas, was chosen, as death data was relatively easy to obtain and the semantic problems of definition would be avoided. While such a study would not necessarily reflect the true incidence of the condition, it would reflect the significance of the ultimate problem—death.

## Melanomas Not Exclusive to Caucasians

Data from the death certificates at the Department of Health and the Hawaii Tumor Registry are tabulated and presented in this paper.

The data in Table 1 show that, while the major problem lies with Caucasians, melanomas are not limited to Caucasians, but affect all major

racess. There is, however, a major difference between Japanese, who have a very low rate, and Caucasians. This racial difference has been reported in other skin cancers.<sup>1</sup>

One must be aware of all lesions in all races that may suggest a diagnosis of melanoma, and must take appropriate steps to differentiate the lesions, either through careful clinical evaluation, biopsy, or both. The numerous black lesions seen in Orientals because of their pigmentary makeup need not call for alarm—but demand concern and evaluation.

## “All That Glisters is Not Gold”<sup>2</sup>

Not every black lesion is a melanoma. Clinical differentiation implies a knowledge of the characteristics of melanoma-like lesions. This includes various nevi—junctional, compound, and intradermal ones; benign juvenile melanomas, and the most interesting halo nevus. Blue nevi are striking in color. Some quite innocent lesions such as seborrheic keratoses, dermatofibromas, and even venous lakes (senile hemangiomas) can create diagnostic problems. Pyogenic granulomas may present melanoma-like lesions, and, not infrequently, pigmented basal cell epitheliomas simulate melanomas. All of these lesions are common but are insignificant as related to mortality. A recent publication of the American Cancer Society, *Ca-A Cancer Journal for Clinicians*,<sup>3</sup> distributed to about 1,800 physicians and other interested people in Hawaii, provides a lucid description and excellent photos of these lesions.

## Hurrah for the Red, White and Blue

Clinical diagnoses of melanomas is a problem for the experts as well as the novice, but Dr. Fitzpatrick<sup>4</sup> of Harvard has suggested looking for certain things. He believes that 90% of clinical lesions can be recognized if the examiner looks for three positive signs of melanoma in a pigmented lesion. Of first importance is variegated

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TABLE 1.—Fatal Melanoma, Hawaii 1961-1975

RACE	NUMBER AND AVERAGE ANNUAL AGE-STANDARDIZED RATE PER 100,000					
	NUMBER OF CASES			STANDARDIZED* RATES		
	TOTAL	MEN	WOMEN	TOTAL	MEN	WOMEN
Caucasian (white)	48	34	14	21.4	30.7	12.2
Chinese	5	4	1	8.7	13.0	3.7
Filipino	6	6	0	6.9	9.5	0.0
Hawaiian, Part/Hawaiian	8	5	3	9.8	12.8	7.1
Japanese	8	6	2	2.8	4.3	1.4
Other	0	0	0	0.0	0.0	0.0
Total	75	55	20	6.5	9.3	3.6

\*Indirect Method

color. "Colors that portend malignancy in a brown or black lesion are shades of red, white, and blue. Of all colors, shades of blue are the most ominous." He states that one must look for an irregular border of the lesion. "An angular indentation or notch is frequently present in the border of a malignant melanoma." He further states that "irregular elevations of the surface are characteristic of many malignant melanomas." This may be visible or palpable and may be discerned more readily in cross light using a 10X hand lens. Itching and tenderness in a mole may suggest a melanoma.<sup>5</sup> These criteria are helpful in deciding whether a biopsy is imperative.

If a biopsy is decided upon, the ideal one is an excision of the whole lesion, thus allowing the pathologist to determine not only the type of lesion but depth of invasion. This has considerable prognostic importance. If the above is not feasible, an incisional biopsy is indicated. "There is no evidence that cutting into a malignant melanoma for a biopsy specimen leads to metastasis of the tumor."<sup>4</sup>

### They Won't Look You in the Eye

This information about the differential diagnosis of melanomas should be helpful—but it will only help if the lesion can be examined. It has been said that malignant melanomas "rarely occur on 'double clothed' areas . . ."<sup>6</sup> While the Hawaii data are not available as to the breasts of women or the bathing trunk area, our data indicated that melanomas must be looked for literally from head to foot and in all orifices. Table 2 indicates the body areas from which melanomas have arisen in this community.

TABLE 2.—Sites of Fatal Melanomas, Hawaii 1961-1975

	TOTAL	MEN	WOMEN
Head and Neck	13	11	2
Trunk	17	14	3
Arms and Shoulders	17	11	6
Legs and Hips	20	14	6
Other	3	1	2
Unknown	5	4	1
TOTAL	75	55	20

These data make it imperative that the public as well as the physician be alerted to this distribution. The primary physician must disrobe the patient and search. Family or friends must aid in alerting patients to lesions in areas normally invisible. Melanomas arising from facial skin occurred only in Caucasians. Of head and neck tumors, one Hawaiian had an onset in the pharynx and one Japanese and three Caucasians had lesions arising from the eye. One Japanese had a vulvar lesion.

### What About Sun?

Most studies have suggested that sun exposure as indicated by geographic latitude plays a role in the development of melanomas. Comparisons of regional data are clouded by a number of factors, particularly race. Table 3 compares age-adjusted incidence rates per 100,000 population of Caucasians from various areas of the United States as reported in *Cancer Incidence in Five Continents*, Volume III.<sup>7</sup> It also shows the latitude of the areas and the percent of days with sunshine.<sup>8</sup>

The information in Table 3 does not support the above concept, even though Hawaii, which is the furthest south, has a high rate and Detroit

TABLE 3.—Incidence of Melanomas in Whites by Latitude and Percent Sunshine

AREA	LATITUDE	SUNSHINE	RATE PER 100,000	
			MEN	WOMEN
Detroit	42 N	54%	2.7	3.1
Connecticut	42 N	57%	4.5	4.3
San Francisco	38 N	66%	6.3	6.6
New Mexico	34 N	77%	4.8	5.3
El Paso	30 N	83%	2.8	4.8
Hawaii	21 N	69%	6.8	5.7



TABLE 4.—Crude Mortality Rates from Malignant Melanoma per 100,000 Whites 1972

STATE	RATE
Michigan	2.0
Connecticut	2.5
California	2.6
New Mexico	2.0
Texas	3.0
Hawaii	4.0

and Connecticut, which are the furthest north, have low rates, since the intermediate areas are not consistent.

Mortality rates for malignant melanoma for 1972, as indicated in Table 4,<sup>9</sup> show a similar pattern for the U.S.A., Michigan and Connecticut having the lowest rates and Hawaii the highest. In this instance, however, New Mexico had a low mortality rate even though it had a high incidence rate.

Our data as to age seem to follow usual patterns, with the highest number of deaths occurring in mid-life, but the rates sharply escalating with increasing age. Rate per 100,000—ages 25-44, 6.0; 45-64, 21.2; and 65+, 72.6.

Rate Increase Only in Caucasians

There are repeated statements in the medical press about the increased incidence of melanomas. In a recent issue of *Skin and Allergy News*,<sup>10</sup> it was stated that "The incidence of melanoma has doubled in the United States and other countries, and mortality has also doubled." Our data support this to a limited degree only. There has been no increase in deaths in any racial group in Hawaii other than Caucasians and particularly Caucasian men.

Summary

Melanomas are not a uniquely Caucasian malignancy. They occur in all racial groups. Malignant melanomas in Hawaii follow usual rates as related to age and latitude. While death rates are increasing in Hawaii as elsewhere, this increase is only in the Caucasian group and then, essentially, in men.

Acknowledgment

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Successful Control of Congenital Oxaluria in Identical Twins

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Primary hyperoxaluria, a relatively rare genetic disorder of oxalate metabolism with calcium oxalate nephrolithiasis, nephrocalcinosis, and progressive uremia, has a 90% mortality within 10 years of onset. Most patients die between the ages of 2 and 10 years.<sup>1,2</sup> The primary hyperoxaluric states are classified as types I and

II. In type I, there is increased excretion of oxalate and glycolate. Excretion of L-glycerate is normal. In type II hyperoxaluria, there is increased excretion of oxalate and L-glycerate, but approximately normal levels of glycolate.

Clinical and pathological feature of the disease is oxalosis, a process of oxalate deposition in renal and extra renal tissues. The hallmark of this disorder is increased urinary oxalate excretion, always found except in end-stage renal failure. The oxalate/creatinine ratio is elevated and

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unaffected by renal failure, therefore useful if the diagnosis is uncertain. The most common clinical problems are urinary tract infection and pyelonephritis secondary to renal damage from oxalate calculi. The oxalate salts may cause local inflammation and fibrosis. It appears that type II primary hyperoxaluria, associated with L-glyceric aciduria, may have slower development of renal insufficiency, despite symptomatic oxalate nephrolithiasis with hematuria and recurring urinary tract infections.<sup>3</sup>

As a primary inherited biochemical disorder, the therapeutic goal for successful treatment of congenital hyperoxaluria is prevention of endogenous oxalate formation. Since most urinary calculi are predominantly calcium oxalate, a therapy that successfully prevents oxalate formation should be effective for both primary and secondary oxaluria. Despite many efforts, no consistently effective therapy has been found.<sup>4,5</sup> Two major approaches have been tried: first, to inhibit enzymes or reduce oxalate precursors, and, second, to prevent stone formation at a given level of oxalate excretion.

The combined use of high-dose oral pyridoxine (100 to 150 mg/day), to modestly reduce oxalate excretion, and oral magnesium oxide at levels to inhibit crystallization, has shown promise in patients with secondary, non-congenital hyperoxaluria and in patients with types I and II primary hyperoxaluria. How important strict dietary oxalate precursor restriction is to the reported effectiveness of pyridoxine and magnesium treatment has not been quantitatively shown.

### Case Presentations

Identical male twins nearly 5 years old, presented in July, 1976, for continued management of their complicated primary hyperoxaluria. Both had required surgical treatment of nephrocalcinosis, beginning in their second year of life. In August 1975, treatment with oral magnesium oxide and pyridoxine was begun. Prior management with low oxalate diet had not reduced

24-hour urine oxalate levels to normal. Since October 1975, with continuation of diet, magnesium oxide, and pyridoxine, both urinary oxalate and clinical course have remained controlled in both twins.

J.H. first had hematuria at 9 months of age, requiring right pyelolithotomy at 13 months for removal of a calcium oxalate stone. He continued to have hematuria every 2 to 3 weeks. An IVP at 3½ years showed multiple stones of right kidney with gross obstruction. He then had another right pyelolithotomy. He was readmitted for left kidney obstruction and had left pyelolithotomy at age 3 8/12 years. At this time the consulting pediatrician suspected primary hyperoxaluria and, therefore, placed the patient on a low oxalate diet with increased fluids. Painless hematuria recurred on the day after patient's fourth birthday. Then oral magnesium oxide, 250 mg. daily, and oral pyridoxine, 50 mg. tid, was started. The changes in 24-hour oxalate excretion are shown in Table 1. Use of medications with glycerol guaiacolate and gelatin capsules caused urine oxalate to rise between February and July, 1976. Since July 1976, treatment has remained the same except for the addition of: 1. restriction of medications with glycerol guaiacolate and gelatin capsules; 2. Bactrim 250 mg. qhs, and 3. supplementary multivitamins without ascorbic acid and supplementary vitamin A.

M.H. (twin of J.H.) first had hematuria requiring left pyelolithotomy and ureterolithotomy for calcium oxalate stone at 14 months of age. He remained symptom free, but due to diagnosis of primary hyperoxaluria in his identical twin at age 3 8/12 years, he was started on the same treatment. Table 1 shows changes in 24-hour urine oxalate excretion before and after oral therapy. This treatment was continued up to the present writing (3/78), with the addition of the same regimen listed for his twin in the preceding paragraph.

Neither twin has shown evidence of new stone formation or urinary tract obstruction or infection since starting combined dietary, mag-

TABLE 1.—24-Hour Urine Oxalate

DATE	24-HOUR URINE OXALATE MG/24 HRS*		TREATMENT
	J.H.	M.H.	
6 - 17 - 75	68	—	None
6 - 27 - 75	51	—	None
7 - 2 - 75	64	64	None
9 - 8 - 75	57	44	Diet only
10 - 17 - 75	23	1	Mg O & vit. B <sub>6</sub> **
11 - 19 - 75	2.9	0.9	Mg O & vit. B <sub>6</sub> **
2 - 11 - 76	10	6	Mg O & vit. B <sub>6</sub> **
7 - 19 - 76	56	71	Medications high in oxalate
9 - 3 - 76	24	32	Restricted medications**
7 - 21 - 77	10.5	—	Restricted medications**
9 - 3 - 78	13	16	Restricted medications**

Normal 20 - 40 mg/24 hrs.

\*\*Diet continued with Mg O and vit. B<sub>6</sub>



nesium, and pyridoxine treatment at age 3 8/12 years. Repeat KUB films, urine cultures, and SMA-6 and 12 profiles have shown stable urinary systems. M.H. had transient hematuria in December 1977, but KUB and urine studies showed no new stones, obstruction, or infection. The symptoms subsided within 48 hours and were explained as possible movement of old renal stones.

### Discussion

No curative treatment for primary hyperoxaluria exists. The most promising palliative regimen consists of: 1. maintaining a chronic water diuresis; 2. low calcium and oxalate diet; 3. minimum ascorbic acid intake; 4. magnesium oxide and 5. high doses of pyridoxine. All treatments and medications have potentially harmful, even fatal, effects. In primary hyperoxaluria, with a most serious prognosis for death from renal failure, certain treatment risks may justifi-

ably be taken.

In the twin cases presented, no evidence of medication toxicity or undesirable side effects appeared. The transient rise in urinary oxalate from glycerol guaiacolate and gelatin capsules was controlled with restriction of use of these agents. At present it is not possible to say conclusively that oral magnesium and pyridoxine are any more effective than dietary restriction alone. Indeed, the excellent dietary control practiced by the twins' mother may have been the major factor in effective therapy.

Biochemical assay to identify these cases as either type I or type II primary hyperoxaluria has not been completed. In face of the continuing apparent excellent clinical and biochemical control, it will be surprising if these twins have type I. The potential application of gained knowledge for others with primary hyperoxaluria will be enhanced when it is determined which type these identical male twins are.

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### Report of a Case

## Gold-Associated Pulmonary Injury

PANU LIMPISVASTI, M.D., and PHILIP JONES, M.D., *Honolulu*

A 57-year-old Chinese woman developed morning stiffness and polyarthritis, involving the hands, feet, and shoulders, in July, 1974. She denied alopecia, photosensitivity, skin rash, Raynaud's phenomenon, inflammatory bowel disease, or dryness of the mouth and eyes. Laboratory studies revealed a normal CBC, urinalysis and SMA-12 biochemical profile. The serum rheumatoid factor and LE prep were negative. Sedimentation rate was 51 mm/hr (Wintrobe method). Treatment was begun with prednisone

7.5 mg and indomethacin 75 mg daily, with marked symptomatic improvement.

The patient was referred to us in September, 1974, and examination showed synovitis involving the wrists, MCP and PIP joints of the hands and the MTP joints of the feet. Laboratory studies again showed a normal CBC with negative rheumatoid factor and LE prep. The serum alkaline phosphatase was elevated to 130 units (normal up to 80 units) and LDH to 350 units (normal up to 210 units). The patient has a history of liver enzyme abnormality since 1969; the liver biopsy then was consistent with anicteric

FIG. 1.—September, 1974



hepatitis. The ESR was 49 mm/hr. A chest x-ray was unremarkable except for minimal bilateral apical pleural thickening (Figure 1). A diagnosis of seronegative rheumatoid arthritis was made. The prednisone was gradually tapered to 1 mg daily and the indomethacin continued at 75 mg daily. Aspirin was begun but could not be increased above 40 grains daily because of tinnitus.

In March, 1976, because of continuing synovitis, gold therapy with gold thiomalate (Myochrysine) was instituted. After 400 mg of Myochrysine, there was no evidence of synovitis and the patient felt well. After 850 mg, the prednisone, aspirin and indomethacin were discontinued and naproxen (Naprosyn) 250 mg b.i.d. was begun for relief of minor residual joint discomfort. In September, 1976, after 1000 mg of gold, the patient began to experience fatigue, anorexia, dry cough, and mild exertional dyspnea.

A CBC showed slight decrease in the hemocrit to 31.4% and a total white blood count of 11,000 with 23% eosinophils. The serum alkaline phosphatase was elevated to 200 and the ESR was 62 mm/hr. A chest x-ray revealed bilateral upper lobe infiltrates (Figure 2). Spirometry showed a mild restrictive impairment (FEVC 60% of predicted).

Extensive studies to determine the etiology of the pulmonary infiltrate were unrewarding. Skin tests for tuberculosis, histoplasmosis and coccidioidomycosis were negative. Sputum cultures for acid fast bacilli and fungi were negative. Sputum cytology was normal. Stool examination for ova and parasites was negative.

FIG. 2.—September, 1976



The possibility of gold toxicity was entertained and both the gold injections and Naprosyn were discontinued. Over the next 2 months, the patient's fatigue, cough and dyspnea subsided. The Naprosyn was restarted, with no recurrence of her symptoms. Chest x-ray in November, 1976, showed significant clearing of the bilateral infiltrates (Figure 3) with complete

FIG. 3.—November, 1976





resolution by January, 1977 (Figure 4). White blood count in November, 1976, was 9,300 with 7% eosinophils, and in January, 1977, was 7,200 with 2% eosinophils.

FIG. 4.—January, 1977



Following the clearing of the pulmonary infiltrates, the possibility of in vivo challenge with gold was considered but was felt to be too hazardous.

### Discussion

Gold toxicity is common during the treatment of rheumatoid arthritis, being seen in approximately 32% of a combined series of 7,693 patients.<sup>1</sup> Most frequently affected are the skin and mucous membranes of the mouth, less commonly the vagina, GI tract, bone marrow, kidneys, and rarely the liver and lungs.

A gold bronchitis has been described<sup>1</sup> and recently Winterbauer and associates reported 2 cases of diffuse reversible pulmonary injury, which they felt was due to chrysotherapy.<sup>2</sup> We feel that our patient fulfills the criteria for a

presumptive diagnosis of gold-induced pulmonary injury. As enumerated by Winterbauer, these criteria are: the development of diffuse pulmonary injury during gold therapy, the reversibility of the injury after discontinuation of gold injections, and the exclusion of other diseases capable of mimicking the clinical illness. Common symptoms in Winterbauer's cases and our case are: weakness, nonproductive cough, shortness of breath, and eosinophilia ranging from 4 to as high as 23%. Additionally all received gold sodium thiomalate. To presume that gold thiomalate rather than gold thioglucose in sesame oil was the inciting agent would at this time be premature and must await further case reports.

The mechanism of injury is thought to be an interstitial pneumonitis which may progress to fibrosis, and in severe cases to respiratory insufficiency.<sup>3</sup> Whether the gold injures the lung tissue directly, or via some immunological mechanism is at present unclear. Davis and Hughes have shown that eosinophilia may precede clinical evidence of gold toxicity.<sup>4</sup> Elevation of IGE in gold hypersensitivity reactions has also been reported.<sup>5</sup> It is of interest that 2 of the 3 patients so far reported have seronegative rheumatoid arthritis and the third has osteoarthritis. This suggests that pulmonary injury may be more common in seronegative cases.

In patients receiving gold, the development of weakness, malaise, dry cough, and shortness of breath, particularly if associated with the development of eosinophilia, should alert the physician to the possibility of gold-related pulmonary injury. Early recognition and prompt cessation of chrysotherapy should minimize subsequent morbidity.

### Summary

A woman who developed bilateral pulmonary infiltrates with eosinophilia during gold therapy for seronegative rheumatoid arthritis is described. Complete resolution of the infiltrates after stopping chrysotherapy and the exclusion of other conditions justify a presumptive diagnosis of gold-related pulmonary injury. The exact mechanism of injury is unclear.

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JON WON

Your "**Leadership Report**" will be a regular feature of the HMA newsletter. It has been felt that, no matter how good communication is, it can always be improved. This your leadership hopes to do in this section. There will be information presented each month regarding those activities and actions of the HMA Council that you need to know about or will be interested in; policies and positions of the HMA, the AMA, and the local county medical societies that you need to recognize; various issues that will be taken up by any of the governing bodies within organized medicine that you will be interested in, and even perhaps, want to make your views known to your leadership before any policy is adopted. Your HMA leadership wants to make this report YOUR report. Let us know what you want to know!

### Leadership Report

Your HMA Council met on December 8, 1978 and February 2, 1979.

**Cancer Commission** headed by Drake Will, M.D., who accepted the chairmanship. HMA Council accepted nominations to the Commission as follows: John Chalmers, M.D., and Verne Waite, M.D., representing DOH; and Reuben Guerrero, M.D., representing American Cancer Society. Other remaining Commission members are Grover Batten, M.D. (HMA), Carl Boyer, M.D. (Cancer Society), Noboru Oishi, M.D. (UH). The Cancer Commission, which oversees operation of the HMA Hawaii Tumor Registry, has encountered some problems, but these are being worked out now.

**CME Director** Nadine Bruce, M.D. conscientiously pursuing attempts to educate physicians about CME requirements which call for mandatory evidence of such CME to obtain new, or renew existing, medical license come January 1, 1980. Dr. Bruce reports that survey shows 30% of physicians in Hawaii have AMA-PRA; 60% of

HMA Councilors have such an award. Thus far, physicians feel HMA should be the central record-keeping body for CME.

**Ad Hoc Committee on Child Health Planning** has developed a Child Health Plan for Hawaii for submission to the Statewide Health Coordinating Council (SHCC) and subarea councils in hopes that it will be included in the State Health Plan. HMA Council accepted the plan as presented.

**HMA-EMS Program** contract with DOH just signed. EMS to provide for training of paramedics, physicians, nurses, public information program, etc., on behalf of State during July 1, 1978 to June 30, 1979.

**Legislation:** Many, many issues of critical concern to physicians are being watched very carefully and immediate action will be taken, if necessary. HMA supports ophthalmologists' stand against allowing optometrists to utilize drugs in their practice, and for valid reasons. Medicaid issue is red hot; DSSH director feels that while he is not against an adjustment in fees paid to providers under Medicaid, DSSH is attempting to delete that section of the law passed last year which makes adjustments mandatory depending upon the Consumer Price Index. The bill submitted also asks that the DSSH be given authority to determine what services it wants to pay for under Medicaid; ie, it could cut out any services it does not wish to pay for. Generic drug substitution is again an issue this year. While HMA supported the concept last year, the report on this issue by the Legislative Reference Bureau has not yet been released; HMA position is that Legislature should wait until the study has been released and reviewed in depth. Other issues to watch are health manpower, cost containment, abortion, minors' rights, mandatory rubella screening, and certificate of need amendments regarding applicability to private physicians' offices.

**Legislative Counsel:** Kazuhisa Abe has again been retained as the HMA Legislative Council for this year.

**Membership recruitment** efforts are where we need YOU! The AMA has embarked on an intensive, three-month membership recruitment campaign (at their expense) for HMA. HMA is also providing intensified recruitment efforts via a recent mailing of a well-designed, good-looking informational brochure on the HMA and its affiliated county societies and the services and benefits of membership. In the final analysis, it is YOU, the member, who can provide the final impetus to many non-members to join with us. Maybe physicians cannot support all positions and policies of the HMA at this time, but there IS SOME COMMON GROUND OF AGREEMENT that must be built upon, and it is on this common ground that we would like to see physicians join with us, be involved with us, participate with us, to see if that common ground of agree-



ment can grow wider and wider! HMA staff is now investigating mechanisms to recruit from the ranks of the housestaff and medical students.

**Treasurer's Report:** For year ending December 31, 1978, HMA total income amounted to \$737,956 with total expenses of \$637,804. Thus, increase in Members' General Fund for the year was \$100,152. Much of the increase was due to HMA participation in federal grants and contracts. The outlook for 1979 is much tighter; HMA leadership needs to keep watch.

**Health Fair:** Can many of you remember 1968? Honolulu County put on a 1968 Hawaii Health Fair—in our opinion, the most successful health fair of its kind to date! Over 2½ days, over 130,000 people viewed 125 exhibits, took advantage of 10 free screening tests, watched a twice-daily disaster exercise, etc., etc. Key to success was physician participation—over 100 providing direct support in health fair committees, probably another three to four hundred in exhibits themselves. HMA Council, upon recommendation of HMA Public Affairs Committee, endorsed putting on a similar health fair in 1981 to coincide with the 125th Anniversary of HMA. More later.

**Wellness Celebration:** HMA, under chairmanship of Dr. David McEwan, voted to support and encourage M.D.'s to participate in the upcoming "Wellness" Celebration scheduled for March 1979, and contributed \$500 toward support of this activity. HMA Council felt that the medical profession has always supported the concept of keeping people "well" rather than concentrating on disease; thus, its support and participation.

**Health Manpower:** UH School of Nursing has submitted a proposal to the federal government to fund a 3-year project to train 75 nurses in its master's degree program as nurse practitioners in three areas of children's health, women's health, and adult health services. Funds requested total \$1,094,000. HMA position communicated to State Health Planning and Development Agency is that such education and training efforts need to be taken in a rational and integrated fashion and in response to a demonstrated or predictable need, and this proposal concerns the HMA. HMA urges that before any definitive action is taken on this proposal, more information and data are necessary.

**Cost Containment:** Big issue both nationally and locally. HMA supports strongly the idea of a voluntary approach rather than government mandate to this problem. HMA has participated in the 9% solution as a co-sponsor of, thus far, three workshops. HMA Health Care Cost Committee has been working hard for six months—will be submitting much information to physicians on ways in which cost containment can be implemented by each and every physician and to make physicians more aware of the costs of health care services. You'll be hearing more very

soon. Interesting note—For 1978, Consumer Price Index rose 9.0%; physicians' fees only 8.8%.

**Rubella Immunization:** Strong push by some segments of community to make rubella testing mandatory to obtain marriage license. HMA position is that because the idea is to catch up on immunization for rubella, a voluntary approach is much more preferable. Also, rubella testing at the time of marriage license application would not target in on appropriate group. HMA will be working hard in the Legislature to get the message across.



## A Dangerous Precedent

A bill pending in the legislature establishes a dangerous precedent of concern to all physicians and their patients.

The bill is a revision of the Optometry Statute (Hawaii 459) which expands the definition of optometry, declaring optometrists able to diagnose **disease** through the use of **diagnostic agents** (drugs) on their clients.

While the proposal appears to upgrade optometric educational requirements, it represents an unprecedented expansion of limited practitioners into the use of pharmaceutical agents.

Many physicians are not aware that optometric "doctors" have no medical training, and are licensed only to "recognize dysfunction," rather than to diagnose disease of the eye. Practitioners of this "measuring science" are quite competent when testing for eyeglasses, but have no experience in clinical pharmacology or pathology, and are generally incapable of recognizing disease of the eye.

Optometrists want to use mydriatics, cycloplegics, miotics and anesthetics to improve their "diagnosis" and referral, while ophthalmologists maintain that optometrists can **detect** visual disorders merely by taking a history and testing the vision. The physicians claim that referrals have

not increased in states permitting optometric drug use, and that this is mere status-seeking at the risk of adverse reactions, which optometrists are incapable of recognizing or treating.

The short course in ocular pharmacology which the optometrists propose would in no way prepare them to understand the complex interaction of these agents with systemic drugs and diseased organs.

Optometrists argue that they see "the bulk of" initial eye exams (studies show this to be about 50%) and that their lower fees will spare the public purse (an Oahu study surprisingly revealed that optometric fees for a basic exam are actually higher, since ODs itemize charges while MDs use a comprehensive fee).

Behind the local skirmish is a ten-year national campaign by the American Optometric Association (AOA), whose current lobby funding is greater than that of the American Medical Association. By pressuring state legislatures, the AOA has managed to obtain drug laws in sixteen states. In six others, the laws are silent or unclear, increasing to twenty-two the number of states in which optometrists use drugs.

While optometrists insist that these states are not reporting adverse reactions, ophthalmologists counter that non-fatal reactions are not reportable, and that even if they were, the present legal climate discourages candor. They point to recent malpractice suits filed against optometrists, and warn that eyes are being needlessly lost.

Any ophthalmologist can cite numerous instances of optometric mis-diagnosis, false reassurance, and delays in referral for treatment. The physicians feel that use of drugs by optometrists will further mislead patients into thinking they have had a competent medical examination, and will further delude optometrists into thinking they have ruled out disease. The ophthalmologists feel optometrists are naively overconfident and, having no experience with disease or with drugs, overestimate both their diagnostic abilities and the benefits of these drugs, while underestimating the hazards.

Optometry has long been in the forefront of what the Bureau of Health Manpower (DHEW) has called "credential-inflation." While optometric education expanded from a three month refraction course to a four year degree program, practitioners became "doctors" whose customers were now called "patients."

Optometry has even rammed drug therapy bills through in a few states following acceptance of diagnostic drugs, and so brazen is the AOA lobby that they now demand national recognition as the primary eye care triage, a position likened to funnelling all community medical care through the local chiropractor.

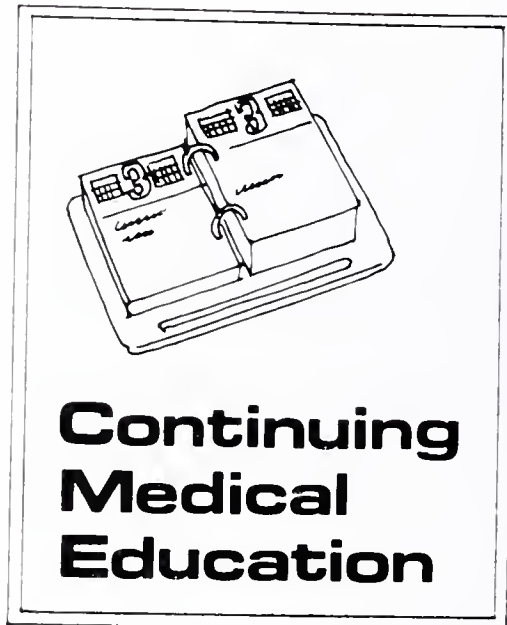
At the crux of the issue is the implied competence in the hands which dispense drugs. If psychologists or audiologists were to follow suit,

the blurred line separating them from their medical counterparts would fade further.

If optometrists can become "doctors by decree," securing status and drugs by legislation rather than education, can doctors of naturopathy, iridology, and chiropractic be far behind?

Hawaii's ophthalmologists are fighting for the health and safety of your patients. If you agree with keeping medicine in medical hands, write your newspaper now, and send a copy to your legislator and the Governor. And ask your patients to write. We need your support.

JMC



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1½ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.



- University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.

#### **Hickam Clinic**

- Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
- Didactic—our staff, 2nd Thursday, 11:00 a.m.
- Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
- Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

#### **Hilo Hospital**

- Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
- NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
- Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
- Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
- C.P.C., 4th Friday, 12:30-1:30 p.m.
- E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
- Visiting Professor's Program
- Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

#### **Kaiser Hospital**

- Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
  - Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
  - OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
  - Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
  - Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

#### **Kapiolani-Children's Medical Center**

- Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
- Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
- Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
- Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
- Tumor Bd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

#### **Kuakini Medical Center**

- Visiting Professor Program
  - Nephrology Conf., 4th Wed., ea. mnth. 8-9:00 a.m.
  - Oncology Conf., every Thurs. 7:30-8:30 a.m.
  - Dept. of Med. Mtgs. & Conf., 3/27 & 3/28—1:00-2:00 p.m.
  - Surgical Conf., 1st, 2nd, & 3rd Fri., 1-2:00 p.m.
  - Surg. M & M Conf., 4th Fri. 1-2:00 p.m.
  - Ophthalmology Departmental Mtg., 1st Tues. ea. mnth. 1-2:00 p.m.
- (Contact CME Dept.-Kuakini for further information)

#### **The Queen's Medical Center**

- Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
- Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium  
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium  
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium  
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
- Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

#### **St. Francis Hospital**

- Visiting Professor Program
- EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
- Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.

- SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
- SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
- SFH-UH Hematology Conf., 3rd Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
- SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
- Tumor Conf., ea. Monday, 7:30-8:30 a.m.

#### **Straub Clinic & Hospital**

- Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
- Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
- General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
- Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
- Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
- Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
- OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
- Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
- Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
- Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
- Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
- Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

#### **Wahiawa General Hospital**

- Noon Seminars, Every Tuesday

#### **Wilcox Hospital (Lihue)**

- Department of General Practice Meeting—last Wednesday
- General Medical Staff Meeting—2nd Tuesday
- Clinical Review Meeting—Alternate Mondays at noon
- Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: I, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

#### **SPECIAL EVENTS**

Mar. 6-10, 1979 U of H Sports Med. Course, Contact: HI Conf. Servs., Harold Brown, P.O. Box 25055 or (808) 377-6445, Honolulu 96825. Reg. Fee HI Residents \$100. Cosponsor: AAFP. Held at Princess Kaiulani Htl. Waikiki, Honolulu. 5 days, 18 hrs.

Mar. 26-28, 1979 Pediatric Post Grad. Seminar—"Problems of Teenage Sexuality," Kap-Childr. Med. Cntr. For info write: W. Schiner, 1319 Punahou St. Honolulu, 96826 (808) 947-8511.

Mar. 31, 1979 "Overview of Hypertension in Hawaii"—2-5:00 P.M. 3 hrs. Cat. I. Held at: Pagoda Htl., Honolulu. Sponsors: HMA, DHEW-NHBL,

- Dept. of Hlth., HI Heart Assoc. No Fee. Contact: Stephen Wallach, M.D. (808) 521-3851.
- Apr. 8, 1979 "Problems in Human Sexuality" 8:30 a.m.-4:55 p.m. 6½ hrs. Cat. 1 CME; 6½ hrs-P. AAFP. Held at: Ilikai Htl., Honolulu. Lederle Labs., HI Nurses Assoc. HMA, HI Pharm. Assoc. No Fee. Contact: CME Dept.-HMA (808) 536-7702.
- Apr. 15-21, 1979 Current Concepts in OB/GYN, Mem. Hosp. Med. Ctr. of Long Beach-Women's Hosp. 2801 Atlantic Ave., Long Beach, CA 90801. Cosponsor: U of CA, Irvine Ctr. for Health Educ. Held at Kauai Surf Htl, Lihue, 06766. 3 days, 24 hrs.
- Apr. 21-28, 1979 Emergency Med-1979 USC Sch. of Med. 2025 Zonal Ave. LA, CA 90033. Held at Royal Lahaina Htl., Maui. 5 days, 30 hrs.
- Apr. 21-28, 1979 Diagnostic & Therapeutic Skills in Internal Med., USC Sch of Med., Div. of Postgrad., 2023 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- Apr. May 18, 1979 Orthopedic Review, USC Sch of Med, Div of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- June 3-9, 1979 Diving Med. U of H Schl of Med. 1960 E-W Rd., Honolulu 96822. Held at King Kamehameha, Kailua-Kona, HI. 6 days. Cat. 1—25 hrs. Contact: CCECS, UH. 2530 Dole St., Honolulu 96822.
- June 18-22, 1979 Comparative Psychotherapies, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina Htl, Maui. 5 days, 30 hrs.

- June 9-16, 1979 Radiology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Htl, Kamuela. 5 days, 30 hrs.
- June 14-20, 1979 "Patient Learning Through Effective Use of Media"—1979 Phys. Seminar on Patient Ed.-20 hrs. Cat. 1 CME. Co-sponsor HMA. To be held at the Kuilima Hyatt Resort Htl. Contact: Media Institute, S 607 1833 Kalakaua Ave., Hono. 96815 or (808) 955-5908.
- June 23-30, 1979 Manipulative Med. USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Sheraton-Waikiki, Honolulu. 5 days, 30 hrs.
- Aug. 4-11, 1979 Ophthalmology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- Aug. 8-22, 1979 22nd Annual Postgrad Refresher Course, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Cosponsor: U of HI. Held: Honolulu, Maui & Kona. 39 hrs.
- Sept. 9-17, 1979 Practical Management of Anesthetic Problems, USC Sch of Med., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 31¼ hrs.

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## OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



## WAHIAWA'S MOST CONVENIENT NEW PROFESSIONAL OFFICE BUILDING

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## Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

**New Members**—None this time.

**Resigned**—Frank Tabrah of the UHSM, who had joined in 1974.

**News of Members**—Homer Izumi has been elected to Life membership. Ernesto Santos has had his membership changed to Inactive because of serious medical problems that have made it difficult to practice actively. Nathan Wong is now an Active member, having finished his Family Practice residency with Kaiser; he is now a full-time physician with the Permanente Group at their Punawai Clinic in Waipahu.



**Michael Padwick** of Kohala on the Big Island hit the newspapers (SB 1/25/79) when he found himself to be the only physician for a community of 3,000 and a workload too heavy for just one doctor; his threat to leave resulted in immediate response when the community and the State persuaded other physicians to come in. Mike, I had no such luck on Molokai when, at times, I was the only one for 5,000 people!

**Jack Stelmach MD**, President of A.A.F.P., and his wife, graced our annual meeting on 27 January and installed the new officers that were elected. He reported in his address to the 54 persons present in the Hilo Room of the Ilikai, that the national academy's membership numbers 42,967; of these 1,120 are Student members and 553 are Resident Affiliates. There were 27 members present at the annual dinner, nearly all of them Active, including new member **Howman Lam**, the two **Newman's**—**John** from Kauai and **Don** from Molokai, and **Ernest Bade** from the Big Island. The presence of the venerable K.C. Chock and wife helped us celebrate the 50 years of active practice by **H.Q. Pang**, his partner, whose wife Minnie shared in the honors bestowed upon H.Q. The Active members present voted unanimously to accept the revised By-Laws of the Chapter together with the "housekeeping" amendments suggested by legal counsel of A.A.F.P.; they also voted unanimously to accept the treasurer's report for the year 1978, copies of which were distributed at the meeting and are available to any member who requests one. An item of pride is that we had four dinner meetings in 1978 for a total of 8 "P" credits, and that our Student members were guests of the Chapter, despite which the Chapter's net liability came up to only \$19.08!

**New Officers**—elected: (**Dave Swanson** succeeds **Tom Cahill** as President); **Patricia Dietrich** as President; **James Tsuji** as Secretary; **Fred Reppun** as Treasurer; for Councillors through 1981: **Don Newman**, **Lincoln Luke** and **Glenn Stahl**; for Delegates to A.A.F.P.: **Don Farrell** and **Felix Lafferty**; for alternates: **Tom Cahill** and **Fred Dodge**; for Nominees to the Honolulu County Medical Society Board of Governors: **Tom Cahill** and **Doris Jasinski**. **Tom Cahill** will continue to serve on the HAFP Council as Immediate Past-president. Incumbent Councillors serving through 1980 are: **Doris Jasinski**, **Pat Walsh** and **Nathan Wong**; through 1979 are: **Fred Dodge**, **Joe FitzHaris** and **Mike Hase**.

**The Mini-Workshop** in "Family and Marital Therapy" with Noble Butler, Ph.D. as the Mainland speaker on 27 and 28 January at Mable Smyth, offered 11 "P" credits. It was attended by 53 persons, of which 27 were members of the Academy; 11 were students of various graduate schools, 3 were Residents and 2 were Physician Assistants.

**Important Notice**—Members whose 3 years of CME (150 hours total of which 75 hours must have been from "P" courses) ended 31 Dec 78 are reminded that they must submit evidence of having taken such Continuing Medical Education by 31 March 1979 or be dropped from the rolls as non-certified for the next three years. It is the member's responsibility to submit his or her hours in appropriate categories; neither our executive secretary nor headquarters in Kansas City with its computer can establish these credits if **YOU** have not kept a tally for yourself, sent it in to Hq, or turned in your yellow and green cards to the computer. Nowadays, the State of Hawaii is in on the act and will not issue you a license to practice medicine next 31

January 1980 unless you establish your CME. Those who hold valid Recertification as members in good standing of A.A.F.P. are almost automatically "in"!

**CME**—of particular local Academy importance up-coming: 6 to 10 March at the Princess Kaiulani and accredited for 18 "P" is the "Annual UH Sports Medicine Course" co-sponsored by HAFP" (\$100 for Hawaii residents). In April there are two events in Ob/Gyn: At the Ilikai 9-13 April "Current Concepts in Ob/Gyn" put on by the U of Washington Seattle for 20 hours "P" at a cost of \$280 tuition; and at the Kauai Surf on 15-21 April "Current Dialogues in Ob/Gyn" put on by Women's Hospital of Long Beach, which has applied for AAFP credit; it already has accreditation for 22 hours of AMA 1. We have advance notice of the 26th annual Pan-Pacific Conference by ACSM (Sports) at the Sheraton-Waikiki on 23-26 May, but no indication of credit hours. The Georgia AFP has announced three home study CME courses in 1979: "Primary Care Up-date," 100 hours, starts 10 September, deadline for application 4 June; "Primary Care of the New-born" for 30 hours credit starts 1 October, deadline 6 July; and "Primary Care Geriatrics" for 30 hours starts 9 October, deadline for application 9 July. The AAFP itself in conjunction with the Florida Chapter is putting on a "Practice Management" workshop in Tampa, Florida, 17-18 March.

**Next Dinner Meeting**—at the **Liljestrand's** on Saturday 24 March; member **Mona Bomgaars** will talk on "Adapting Family Practice to a Developing World" and since it involves medical as well as medical-economic aspects, she might be on for two hours. Mona is currently in India.



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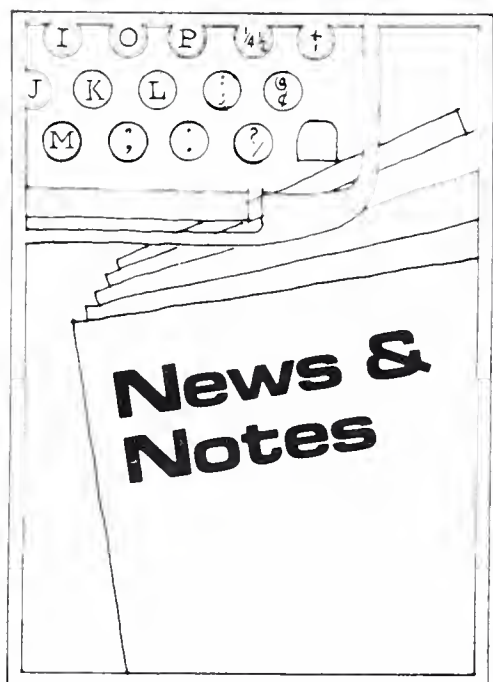
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Paul S. Isenburg, Ph.D.  
Director  
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HENRY N. YOKOYAMA, M.D.

## Professional Moves

The traditional "Kung Hay Fat Choy" (Have a prosperous year) or "Gung He Xin Nian Kuai Le" (Mandarin for wishing you a happy new year), or whatever, the Year of the Ram is with us. Unlike its predecessor, the boisterous Horse Year, the Ram Year is behaving like a meek sheep rather than a rampaging ram for we see few changes thus far . . .

In February, urologist **George Kenessey** relocated to 302 California Ave., Suite 208 in Wahiawa . . . Internist **Cornelia DeLeon** opened her office at 2215 N. School Street and OB Gyn man **Nihal De Silva** joined The Fronk Clinic Pearlridge in Aiea.

On the Big Island, **Charles Morin** and nurse **Frances Woolard** will open a general practice clinic in Kohala on March 1 . . . Neonatologist **Larry Tinsley** has joined the Kona Medical Associates' Kailua office . . .

**Richard Littenberg**, co-medical director of the Honolulu Medical Group, announced that the Group will start twice weekly evening hours from 5 to 9 pm on Tuesdays and Thursdays. Physicians in six departments will be on duty and X-ray and path lab facilities will also open.

Talented author-lecturer **Ron Pion** who has moderated HMA's "Your Body, Your Mind" and "Health Conversations" TV series for 3 years will move his family to L.A. where he is doing an "Alive and Well" medical spot on KNBC-TV newscasts . . .

## Elected, Honored & Appointed

Amiable Dean **Terence Rogers** of our UH School of Medicine (whose doctoral training and research were in nutrition) will take a leave of absence until June 30, 1980 to be principal scientific adviser to President Carter's Commission on World Hunger . . . The commission was established in October and is charged with developing and implementing the U.S. government program against hunger . . . **John Wellington** will be acting dean in Terence's absence . . .

Straub orthoped **Donald Jones** has been named chief of staff at Shriner's Hospital for Crippled Children . . . **R.C. Dusendschon** was appointed high priest and prophet of the Aloha Shrine Temple . . .

## The Prescription—(An anecdote)

"May I confess to something? Even with a father-in-law who is a surgeon, one thing I've never been able to learn about your profession; where do you learn to write those prescriptions?"

"I have a friend and he's an absent-minded professor type. The doctor gave him a prescription. He put it in his billfold and then absent-mindedly forgot all about it. Sometime later when he took it out he couldn't remember what it was for. He showed it to the conductor on the commuter train and for two years rode free. They thought it was a railroad pass. Once he got into a ball game with it. He showed it to the cashier where he worked, and she thought it was a note from the boss and gave him a raise. He laid it down on the table at home, his daughter picked it up, played it on the piano, and won a scholarship to the National Conservatory." (Opening remarks by Ronald Reagan in an address to the Association of American Physicians and Surgeons, Denver, Colorado on Oct. 6, 1978 . . . Submitted by ever faithful contributor Irene Wong, HCMS secretary.)

## Life In These Parts

"Schools add a new course: Russian flu now on agenda" read the headline . . . So we perused the article with consuming interest only to discover that Public Health epidemic intelligence officer Methsiri Gunaratne was merely reporting that absentee rates in Hawaii schools were climbing because of A-USSR cases . . .

### Nuclear Holocaust?

At 2:30 pm at Queen's Medical Center on Feb. 6, a smidgen of powder—10 milligrams—created quite a stir . . . A radium capsule was being returned to a lead-lined drawer in the radiation therapy room when one did not drop all the way into its slot. A technician closed the drawer, and the top of the capsule broke off, spilling the powder. The technicians immediately shut down the air conditioning and the exhaust system and sealed off the room with tape. They were scrubbed down and surveyed with Geiger counters and found free of contamination. The Honolulu Fire Department personnel and a DOH representative were summoned. A physicist from Tripler and his assistant entered the room, gowned and masked. They carefully picked up the contamination on masking tape; scanning and taping, scanning again and taping again, till the contamination was absolutely gone . . . At 7:30 pm, the room was finally given the all-clear . . . Real life drama in action . . .

The Kapiolani—Children's Medical Center's medical genetics office headed by **Edward Hsia**, professor of genetics and pediatrics, has a new computer terminal which is hooked into the central computer at the Center for Birth Defects Information Services at Tufts-New England Medical Center. The Birth Defects Information System (BDIS) which provides up-to-the-minute information on more than 1,000 different birth defects was developed jointly by the National Foundation, Tufts-New England Medical Center and the Massachusetts Institute of Technology. Ed Hsia reports that about 500 babies may be born every year in Hawaii with serious birth defects and the computer offers physicians and researchers instant retrieval of birth defects information gathered from leading institutions around the world in a matter of minutes . . .

The DOH is seeking \$5-million to expand the Emergency Medical Services program to the Neighbor Islands as called for in a bill passed by the 1978 Legislature. Henry Thompson, deputy health director, reports that EMS service on Maui is ready to go and on Kauai in the next two years. It may be another two or three years to put EMS into effect on the Big Island.

The DOH and the Agriculture Dept. jointly announced that hog viscera sales will be resumed since pasteurization procedures are working out well. **Wayne McKinny**, who has been crusading against hog viscera sales, immediately termed the decision a mistake. Wayne admits that pasteurization works to some extent but feels that a ban on its sale is far more effective in controlling the high salmonella rate in Hawaii . . .

### Cost Containment?

The state is contemplating a 10 percent raise in rates for its 13 hospitals. The state last raised its hospital rates in 1977 with hikes of 30% for 1977-78 and 10% for 1978-79. Health



director **George Yuen** explained, "We're trying to keep it as close as possible to President Carter's guidelines (of 7 to 9%). Taken over a two-year period, our increase would not be as large as the private hospitals'."

In the wake of the asbestos scare at PHNY, the State Division of Occupational Safety and Health has been doing air sample tests since mid-January at five schools . . . The sampling was prompted by the presence of asbestos in the school room ceilings and the report has been negative thus far.

"Official Tattoo Inspector"—Dermatologist **Norman Goldstein** (who wrote "The Skin You Live In" and who has another book being published, "The Skin You Love In") became the darling of the tattoo underground in San Francisco where at the American Academy of Dermatology meeting he showed his exhibit, "The World of Tattoos" . . . Norman was invited to the Tattoo Ball where everyone came tattooed or in costume. Norman attended as a white-coated doctor with the label, "Official Tattoo Inspector." Recognition has come from other parts of the world and he is now an honorary member of one of the largest tattoo societies of Japan. He received a Christmas card from the society with the photograph of the nude, fully-tattooed, colorful body of one of its female members. "It's an art form," Norman keeps repeating . . .

A 41-year-old man bleeding seriously from a duodenal ulcer and admitted to Maui Memorial Hospital refused transfusions for religious reasons. **Louis Rockett** obtained a court order to transfuse the critically ill man, and the patient finally agreed to be transfused only if the blood was from a vegetarian. This was arranged and the patient was saved . . . James Kreuger, Wailuku attorney who obtained the court order, commented, "The important thing to note is that a doctor and a judge decided on some courageous action to save a man's life."

**Ned Wiebenga**, chief of the DOH's epidemiology branch, announced that some 200 students were suspended from school until they complied with Hawaii's immunization law wherein students entering school for the first time are required to have immunization against diphtheria, tetanus, whooping cough, polio, measles and rubella. The state law affected 21,000 students entering school for the first time in the fall . . .

Fourteen states, including Hawaii, allow patient access to medical records. The Hawaii law states that "if a patient requests copies of his or her medical records, the copies shall be made available unless in the opinion of the health care provider it would be detrimental to the health of the patient to obtain the records." A pamphlet, "Getting Yours: A Consumer's Guide to Obtaining Your Medical Record" may be purchased for \$2 from Health Research Group, Dept. MR, 2000P St. NW, Suite 708, Washington, D.C. 20036. The U.S. Office of Consumer Affairs urges patients to know and assert their rights . . .

## Aphorisms

"Apology is only egotism turned wrong-side out."  
(Oliver Wendell Holmes)

"A good surgeon must have an eagle's eye, a lion's heart and a lady's hand."  
(Proverb)

"Success covers a multitude of blunders."  
(George Bernard Shaw)

"The art of being wise is the art of knowing what to overlook."  
(William James)

"Use not only all the brains you have, but all you can borrow."  
(Woodrow Wilson)

"Law of Probable Dispersal: Whatever hits the fan will not be evenly distributed."  
(From Nadine Bruce's paper and submitted by Toni)

## Hors De Combat

It seems that Lanai's two health care facilities are often antagonistic camps . . . **James Langworthy** is Lanai's only doctor and heads the private Lanai Clinic. Across the parking

lot is the state-run Lanai Community Hospital. Jim often orders a Multi-42 which has 42 specific test results which costs the hospital \$23 for sending it to a mainland lab . . . Until recently the hospital charged a \$2.16 handling charge, but in October, hospital administrator Dick Pittsinger raised the fee to an astronomical \$59.08 . . . The state did not agree with this raise and ordered Pittsinger on Jan. 18 to rescind the excessive fee and to reimburse all those parties overcharged . . .

An attorney in the FTC's Bureau of Consumer Protection, a Peter Holmes, testified before the Senate Health Committee that a law allowing pharmacists to select generic drugs for their customers could save Hawaii consumers as much as \$1.2 million a year.

The State Board of Optometry has introduced a bill which would allow optometrists to use four classes of eye drops, viz cycloplegics, mydriatics, topical anesthetics, and miotics in their diagnostic eye examinations . . . Apparently 22 states permit the use of these drugs as diagnostic tools. **John Corboy**, acting as spokesman for the dissenting ophthalmologists, says that the drugs are potentially dangerous and should not be available to professionals who aren't trained to use these drugs. John feels that optometrists aren't trained to diagnose diseases of the eye, but are trained to recognize symptoms of eye trouble and should refer such patients to an ophthalmologist. Fellow ophthalmologist **Bob Wong** wrote in a letter to the editor: "The danger of this proposition (Optometric Act revision) is two-fold: First, all ocular diseases and pathology are related to systemic disease. Second, all diagnostic ocular medications also have therapeutic functions and potential systemic effect. Optometrists are lacking in training, experience, and exposure to systemic diseases and the acute emergencies that may arise from the use of drugs. Competence must be earned, not legislated. Granting the optometrist the right to use drugs would provide him with a false veneer of competence regarding all aspects of its use . . ." (Makes good sense . . .)

Maui physicians are unhappy about State Health Director George Yuen's rejection of a proposal for the takeover of



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Maui Memorial Hospital's administrative functions by a private management firm, the Hospital Corp of America. George feels that the corporation's proposal would cost the State about \$400,000 a year and would be too costly. He urged the hospital's staff to forget their difficulties of the past and join him in forging new standards, not only for Maui Memorial, but for the state's other state-run hospitals as well. **John Withers** told Yuen that the hospitals' problems remain unsolved because of an inadequate budget. "The doctors are not happy with you. We want the HCA." John also said that if the hospital does not receive more state funds, it should raise its rates so that the institution will be able to improve its facilities and services.

## Visiting Physicians

**Norman Shumway's** lecture on Jan. 26 at Kam Auditorium . . . Incomplete notes therefrom:

"From 1968-78, 160 patients have had 171 heart transplants . . . More re-transplants in recent years . . . Referrals from all over the U.S. including 1 tragic case from Honolulu who had a cardiac arrest . . . Results: 74 patients lived 1 year . . . 91% of the 74 were successfully rehabilitated with improved quality of life . . . One patient was a professional athlete who went back to work . . . Dx in the 161 patients: End stage coronary artery disease . . . Idiopathic cardiomyopathy . . . Valvular disease . . . etc . . . Overall: 20% with 5 year survival . . . Recently 60% with 5 year survival . . . Without surgery, all patients would have died within 1 year . . . We do periodic endocardial biopsies for early dx of rejection and treat aggressively . . . 13 patients had re-transplants . . ."

Slide: Cover of 1971 issue of LIFE showing vivid photograph of a heart being transplanted with the heading: "Tragic Report on Cardiac Transplants". Norman's comment: "No wonder LIFE had an early demise."

"Odds for survival have increased slowly in the past 11 years . . . half of transplanted patients can expect a live year survival . . .  $\frac{2}{3}$  of the patients can expect one year survival . . . We have done 174 transplants on 161 patients in 10 years with 67 still living . . . one patient has survived eight years and eight months . . . With the use of ALG since 1974, the survival rate has increased . . . The one year survival rate has risen from 22% to a high of 70% in 1977 . . . whereas 50 patients for whom we could not find donors died within 9 months, most of them surviving less than 6 months . . . 20% of the recipients rejected their transplanted hearts outright . . . A larger number succumbed to rejection and infections . . . The youngest heart transplant patient was a 12-year-old . . . Stanford gets 200 to 250 requests a year and 80% are rejected because of age and other medical reasons . . ."

"Current Concepts in Treatment of Common Rheumatic Diseases" **Charles Smith** from Denver at Kahala Hilton 1-26-79, courtesy Merk Sharp & Dohme:

"Rheumatic diseases affect 31.6 million in the U.S. It's the most common non-fatal chronic condition and costs \$14 million dollars per year . . . Rheumatoid arthritis and degenerative joint diseases comprise 75% of all cases . . ."

Clinical course of RA: Stages I to IV (Staging by X-rays), Monocyclic: (involves single episode) 35% of cases, Polycyclic: (many episodes) 50%, Progressive: 15%.

End results of RA without Rx: Remission or improved 48%, unimproved or worse 50%, Helpless 10%.

Drugs with established value in RA: Salicylates, acetaminophen, non-steroidal, gold, corticosteroids, antimalarial, cytotoxic agents, D-penicillamine.

Salicylates: Most widely used agent . . . Proven anti-inflammatory . . . Must use enough . . . ie 10 to 16 V gr tabs to attain 20-30 mg % blood salicylate levels.

Acetaminophen: No anti-inflammatory effect, analgesic only.

Non-Steroidal: Butazolidin, Tandearil: esp. for gout and ankylosing spondylitis . . . Indocin: +10 years in use; GI symptoms . . . Motrin: Used in inadequate doses . . . Comparable with aspirin . . . Naprosyn, Nalfon: Lower toxicity (ie GI, hematopoietic and renal).

Sulindac: Released in Nov. '78 . . . Fluorinated derivative of indometha . . . Cross over and double blind studies show efficacy . . . FDA recommends 2-3 tabs/d . . . Approved for ankylosing spondylitis, juvenile arthritis, osteoarthritis, gout, painful shoulder . . . 16.4 hr  $\frac{1}{2}$  life . . . peaks in 2-3 hrs . . . comparable with 12-14 aspirins . . . no GI symptoms . . . low fecal blood loss . . .

Gold: 30-40 years of experience . . . safe in pregnancy; salicylates can cause small infants even when given at term of pregnancy . . . other non-steroidal agents may also be safe in pregnancy . . . 75% effective . . . give increasing weekly doses to a maximum of 1000mg . . . Continue Rx 6-8 mos. after remission . . . Check urine weekly for proteinuria . . . Stop Rx with 2 plus proteinuria . . . Use Au with caution; check Hb, WBC & UA before each injection . . . Proteinuria may last 9-12 mos . . .

What and When to Use? Relate to stages . . . Analgesics for Stages I-IV . . . Anti-inflammatory agents in early stages only . . . Rehab measures in Stages III & IV . . .

D-penicillamine . . . Equal to Au in efficacy . . . Watch Hot and for proteinuria hematuria . . . "Go Slow, Keep Low . . ." Dose: 250mg tab 6-8 wks, 500mg tabs 8-10 wks, 750mg tabs (Maximum).

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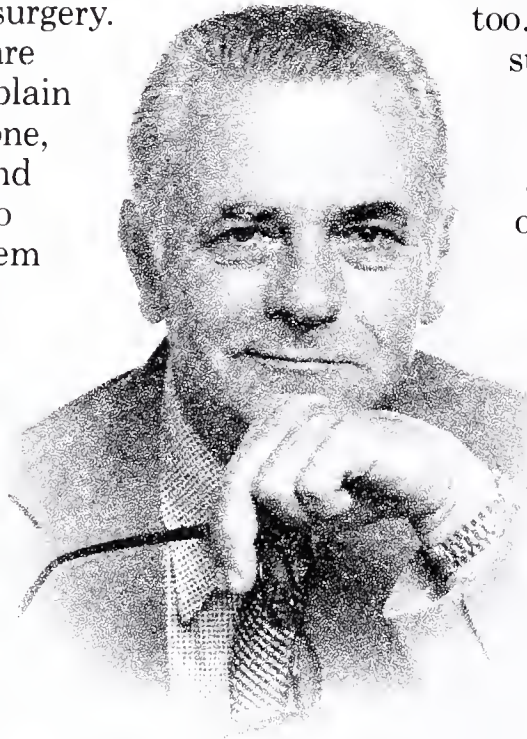
We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

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# Hawaii Medical Journal

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**Indications and Usage:** For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides, pregnancy; nursing mothers; infants less than two months of age.

**Warnings:** BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A  $\beta$ -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura; hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum

sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

**Dosage:** Not recommended for infants less than two months of age.

**URINARY TRACT INFECTIONS IN ADULTS AND CHILDREN AND ACUTE OTITIS MEDIA IN CHILDREN:**

**Adults:** Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

**Children:** Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

**Children two months of age or older:**

lbs	Weight kgs	Dose—every 12 hours	
		Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

**For patients with renal impairment:**

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,  
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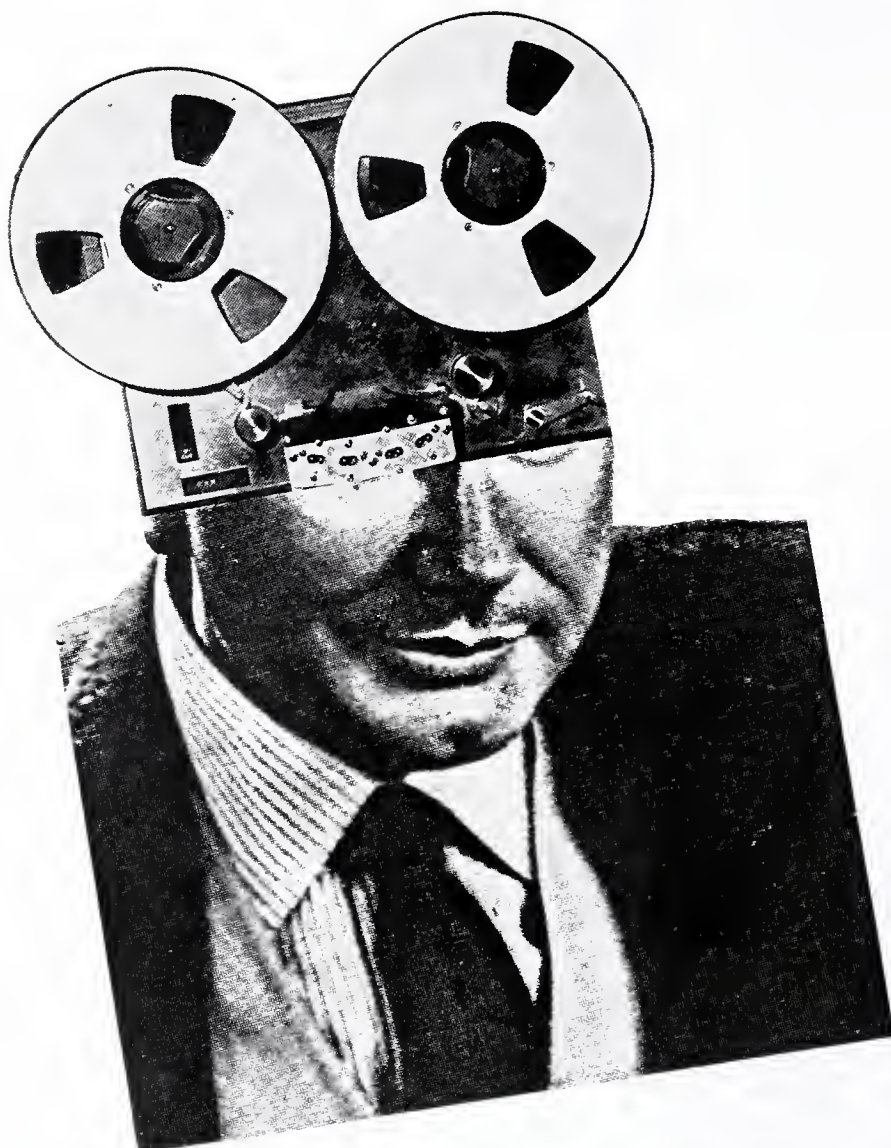
specimens, and confirmation of the positive TINE TEST using the Mantoux method. In general, the TINE TEST does not need to be repeated. Antituberculous chemotherapy should not be instituted solely on the basis of a single positive TINE TEST.

**Adverse Reactions:** Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons. Pain, pruritus and discomfort at the test site may be relieved by cold packs or by a topical glucocorticoid ointment or cream. Transient bleeding may be observed at a puncture site and is of no significance.

**Reference:** Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.



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# Changing Admission Patterns at Hawaii State Hospital Following the 1976 Revision of the Hawaii Mental Health Statutes

HOWARD E. GUDEMAN, Ph.D., MARY I. NELSON, M.S.W., LYN J. KUX, B.A.,  
and LARRY F. SINE, M.A., Honolulu

● *During the last decade, the civil and consumer rights movements in the United States have focused upon mental health programs. As a result, the judicial system has handed down decisions that in turn have required new legislation. The state of Hawaii, consistent with this nation-wide trend, amended its mental health statutes. These amendments involved both substantive and procedural changes that potentially could serve to modify both the type of patients entering the hospital and their status at the time of their entry.*

In June 1975, the Supreme Court of the United States handed down the *O'Connor v. Donaldson* decision, 422 U.S. 563 (1975), concerning the constitutional rights of a civilly committed mental patient. It was the first time in this century that the high court rendered an opinion relative to the civil rights of individuals committed to mental hospitals. The *Donaldson* decision concluded that "... a state cannot constitutionally confine . . . a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

In addition to limiting the state's power to commit, the *Donaldson* decision also addressed itself to the process whereby a state may confine a person to a mental facility. "There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the state cannot accomplish without due process of law . . . Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceed-

ing. Equally important, confinement must cease when those reasons no longer exist . . ."

Judge Samuel King in discussing his *Suzuki v. Quisenberry* decision, 411 F. Supp. 1113 (D. Haw, 1976), noted that "... the overriding consideration behind recent cases that have struck down the relaxed procedures for hospitalizing a person for mental illness, whether or not he consented, has been that personal freedom is involved. . . . the diagnosis and treatment of mental illness leave too much to subjective choices by less than neutral individuals. In this Bicentennial Year, celebrating among other things the declaration that all men are endowed by their Creator with the unalienable rights of Life, Liberty and the Pursuit of Happiness, a state law authorizing the indefinite detention by force of an individual, solely on the certificates of two physicians stating that the individual is so mentally ill that he needs hospitalization, cannot be sustained."

To correct what Judge King found to be unconstitutional aspects of Hawaii Revised Statutes, Chapter 334, dealing with Mental Health, Mental Illness, Drug Addiction and Alcoholism, a revised mental health law, Act 130, was approved by the 1976 Legislature. A consequence of this revision has been a change in the legal entry status of patients admitted to the hospital. This change involves an increase in the percentage of patients entering for emergency examination and hospitalization. On the basis of an *ex parte* order by a judge or as the result of an examination by a licensed physician, an individual may be hospitalized up to 48 hours if there is probable cause to believe that the individual is 1) mentally ill or suffering from substance abuse, and

2) imminently dangerous to self or to others, and 3) in need of care and/or treatment. At the end of 48 hours, the patient must be released unless he or she voluntarily agrees to continued hospitalization or a petition is filed for a hearing to bring about civil involuntary hospitalization. When a petition is filed, the hearing must be scheduled no later than 10 days after the filing date.

This report examines entries to Hawaii State Hospital from June 1976 through September 1978, the first 28 months the revised mental health statutes were in operation. The initial section delineates the legal status of the 1,946 entries and graphically represents changes that have occurred during this period. The second section traces these approximately 2,000 admissions by means of a flow-chart to characterize changes in the legal status of the patients as they move through the admission procedures towards hospitalization or return to the community. The final section summarizes a detailed analysis of 407 patients entering the Hawaii State Hospital for emergency examination and hospitalization, and compares the patients who elected to enter the hospital voluntarily with those who con-

tinued to be patients only on the basis of a court determined civil involuntary commitment.

**Changes in Admission Patterns Subsequent to Act 130 (June, 1976 through September, 1978)**

Figure 1 describes changes in the legal entry status of patients admitted to Hawaii State Hospital subsequent to revision of the Mental Health Law (Act 130).

There has been a progressive decline in the number of patients entering the hospital. As can be seen in Fig. 1, a sharp decrease in the number of voluntary admissions appears to be primarily responsible for the decrease in total admissions. These statistics indicate that, subsequent to the 1976 revision of the Hawaii Mental Health Law, the number of patients entering the hospital on a voluntary basis has decreased while emergency admissions have tended to increase. In addition, these statistics also suggest an associated gradual increase in the number of patients entering under the penal code, eg, having criminal aspects to their incarceration. Although gradual, the increase in penal code patients has been consistent and has reached significant proportions over the last 5 years. Review of hospital penal code admis-

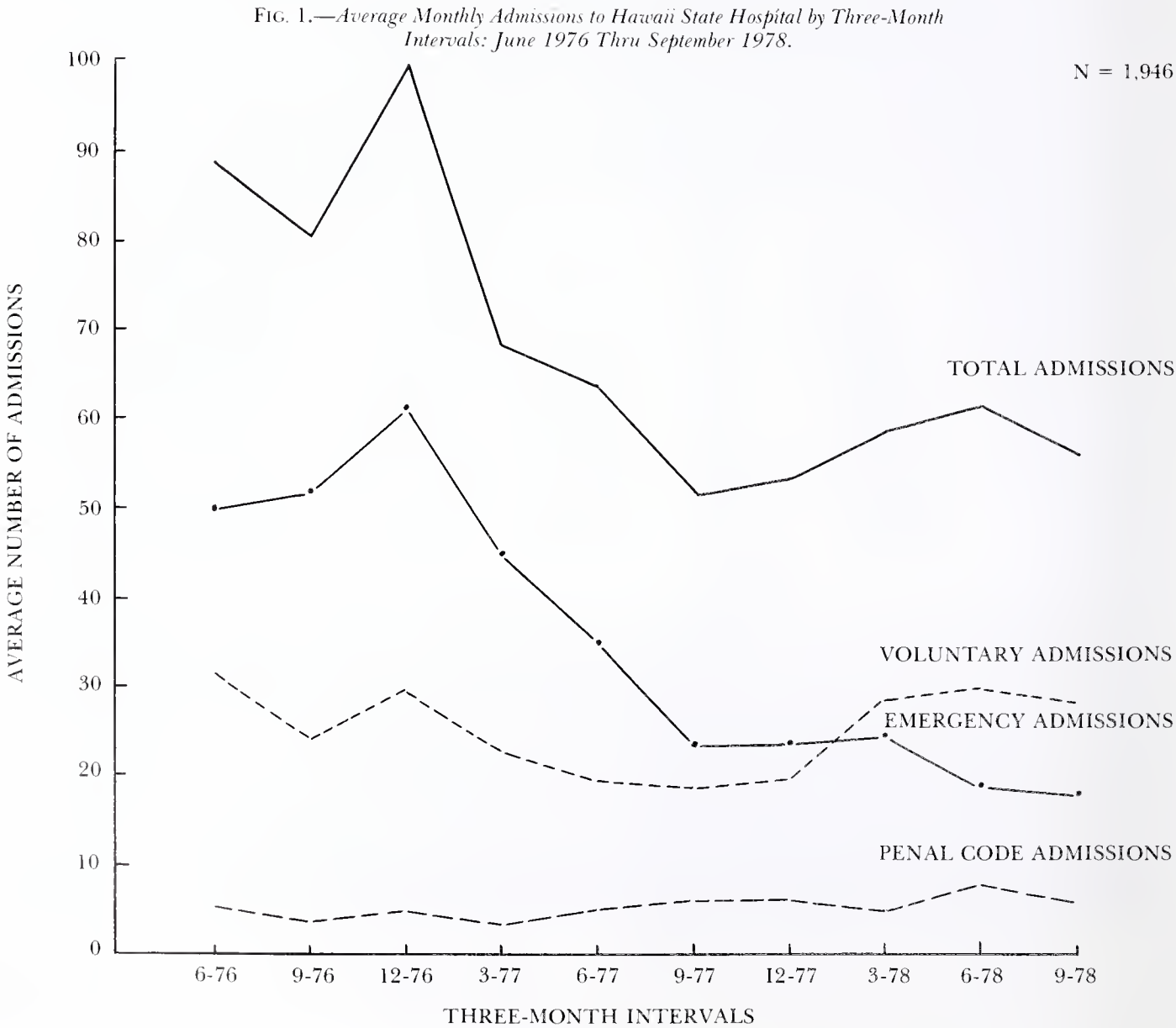




TABLE 1.—*Number, Admission Status, and Criminal Charges of Penal Code Commitments to Hawaii State Hospital—January 1974 Through October 1978.*

YEAR	NUMBER OF PENAL ADMISSIONS	RATE PER MONTH	EXAMINATION (SECTION 404)	ADMISSION STATUS		CRIMINAL CHARGES		
				UNFIT TO PROCEED (SECTION 406)	ACQUIT & COMMIT (SECTION 411)	OTHER	FELONY	MISDE- MEANOR
1974	18	1.50	7	0	9	2		
1975	33	2.75	9	6	6	12	90%	10%
1976	52	4.33	30	6	12	4		
1977	69	5.75	39	10	14	6	50%	50%
1978	73	7.30	32	14	26	1		

(Thru Oct.)

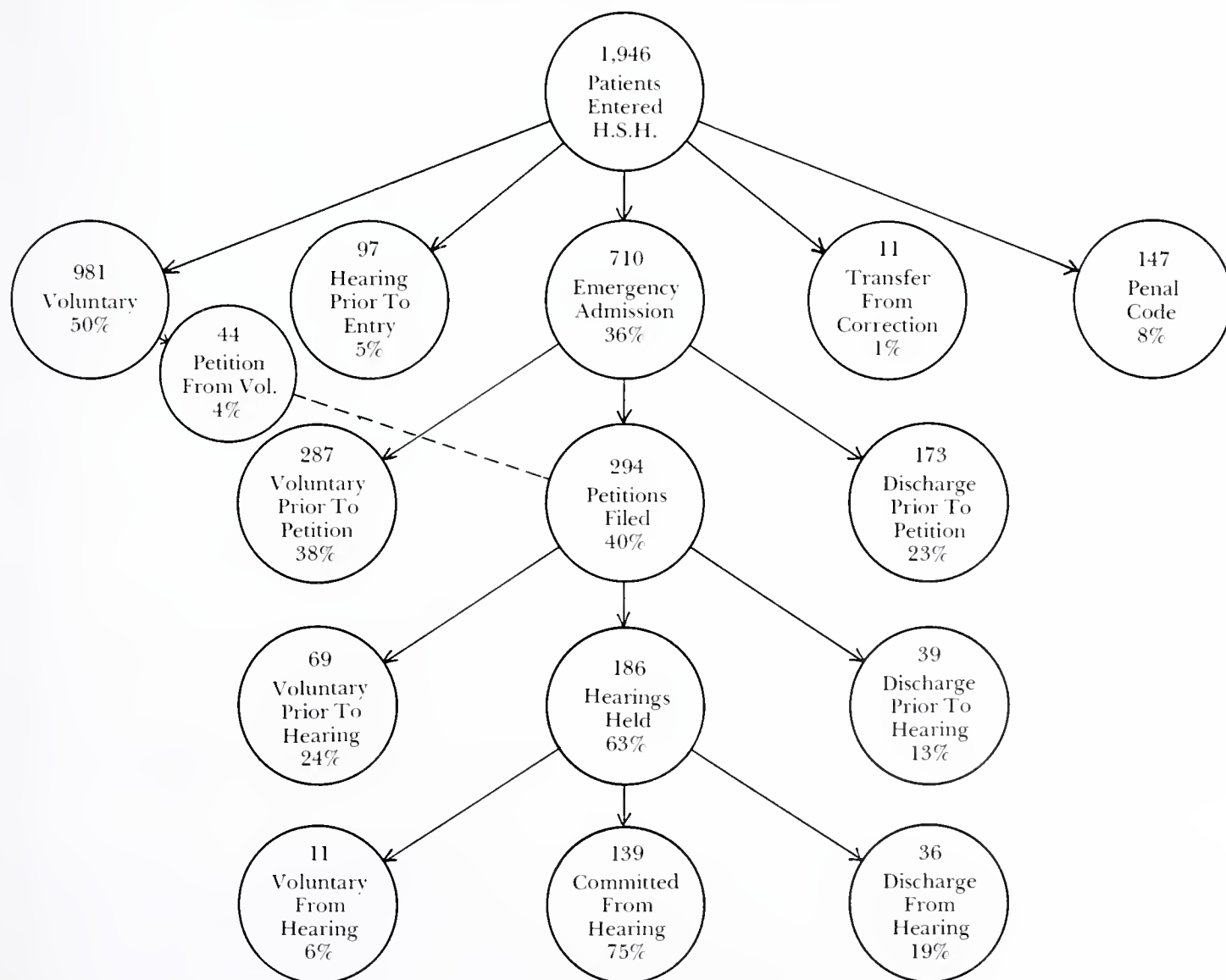
sions, as presented in Table 1, indicates that 4 times as many penal code patients were admitted during the first 10 months of 1978 as were admitted during all of 1974.

In addition to a greater number of penal code patients entering the hospital, there has also been a reduction in the severity of the criminal charge associated with these entries. During the 2-year period, 1974 to 1975, 90% of the penal code patients entering Hawaii State Hospital carried felony charges while 10% were charged with misdemeanors. Statistics for the last 2.5 years, since revision of the mental health statutes, indi-

cate there is now an equal number of misdemeanor and felony cases entering the hospital. Does this increase in the number of "misdemeanor" persons being hospitalized with minor charges indicate that the relatively more stringent criteria for civil involuntary commitment may have served to "criminalize" some mental patients?

These statistics suggest that mental hospitalization may be in the process of again becoming more of a legal coercive act rather than a voluntary medical decision. This change may represent a step backward in the theory and practice of

FIG. 2.—*Changing Status and Disposition of Entries to Hawaii State Hospital, 5-21-76 Thru 9-30-78.*



mental health, as it exists today, by requiring such restrictive due process that an individual's right to be free overrides and precludes his right to treatment. In other words, the legal aspects of civil commitment may have reduced the probability of hospitalization for many patients who need but do not have the capacity to seek mental health care for themselves.

### **Patterns and Changes in the Legal Status of Patients Entering Hawaii State Hospital**

During the 28-month period since Hawaii revised its Mental Health Law, there have been 1,946 entries to the State Hospital. Figure 2, which includes multiple entries, describes the legal status of these patients at the point of their entry to the hospital, and traces changes in their legal status until their hospitalization was established or until they were returned to the community.

A descriptive overview of the flow-chart indicates that 50% (981) of the entries to the hospital were voluntary, 36% (710) were admitted on an emergency basis, while 8% (147) came into the hospital under the penal code. The remaining 5% (97) of the entries were transfers to the hospital from other agencies, with their legal commitment already determined, and 1% (11) were transfers from correctional agencies.

The remainder of the flow-chart is concerned only with the emergency admissions and the manner in which their 48-hour emergency status is resolved. There are 3 possible alternatives, including 1) entering the hospital on a voluntary basis, 2) being discharged back to the community, or 3) petitioning for a civil involuntary hearing before a judge. As noted in the third level of the flow-chart, 294 (39%) of the emergency entries had a petition filed for a hearing. This number includes 44 voluntary patients whom the hospital staff considered as dangerous; thereby meeting the criteria for involuntary commitment which led to a petition for a civil commitment for the safety of the patient and the community, rather than allowing the patient to remain on a voluntary status.

To summarize Fig. 2, 49% of the emergency admissions, including the voluntary admissions for whom petitions were filed, eventually become voluntary patients; 33% were discharged prior to, or as a result of, the hearing, and only 18% or 1 in 5 of these individuals were able to meet, within the 10-day specified period, the more stringent requirements of imminently and substantially dangerous, beyond reasonable doubt, to qualify for an involuntary admissions.

### **Resolution of Emergency Hospitalization**

The level of evidence necessary for an emergency hospitalization is "probable cause." That is, a judge may issue an *ex parte* order or a psychiatrist may request emergency hospitalization

upon documentation that there is a good probability that the individual is dangerous to himself or to others and requires treatment for mental illness.

As noted in Fig. 2, approximately 38% of the individuals who entered Hawaii State Hospital on an emergency basis (including the voluntary admissions for whom petitions were filed) voluntarily agreed to further hospitalization within the 48-hour period allowed for resolution of their emergency status. Thirty-nine percent met the criteria for involuntary hospital commitment and had a petition filed. The remaining 23% were discharged from emergency status and returned to the community. This section provides a detailed analysis of 407 patients for whom continued hospitalization was the resolution of their emergency admission to the Hawaii State Hospital. These patients represent an unduplicated count of all emergency admissions for the 24-month period from May 21, 1976 through May 21, 1978. Included in the population of 407 are 141 patients who volunteered to remain hospitalized and 266 for whom petitions were filed for a hearing before a judge.

The purpose in studying these 2 groups is to identify the environmental factors and characteristics of the patients who elected to enter voluntarily, when 2 days earlier they required an *ex parte* order by a judge or an examination by a physician to establish probable cause that hospitalization was, in fact, needed. The 48-hour period in residence on the ward was sufficient to convince  $\frac{1}{3}$  of these patients that it was appropriate to remain hospitalized. For the remaining  $\frac{2}{3}$ , it was considered necessary to petition for involuntary hospitalization. Are there systematic and significant differences between these groups that would help explain their acceptance or reluctance for continued hospitalization?

Four levels of data were collected on all 407 patients who remained hospitalized as the resolution of their emergency status:

1. Demographic characteristics, including age, sex, ethnicity, marital status, geographical area of residence, household composition, occupation, education, referral source, indication of previous psychiatric care, means of support for the patient, previous incarceration in a penal institution and previous number of admissions to the hospital.
2. Factors precipitating hospitalization, including person bringing need for hospitalization to attention of responsible and facilitating agents, reason for admission and type of behavior precipitating emergency hospitalization.
3. Hospital-related factors, including diagnosis, ward assignment, ability to communicate with hospital staff, mental status examination, risk factor designated by hospital staff and type of medication prescribed during the 48-hour period.



4. Length of hospitalization: as a last variable, the average length of hospitalization for the two groups was compared to determine if there was any significant difference in the amount of time voluntary patients, in contrast to involuntary patients, remain in the hospital.

Data were collected to determine what constellation of factors may be related to a patient's willingness to enter the hospital voluntarily, rather than precipitating a petition requiring a judge to make the decision. Are demographic characteristics of age, sex, ethnic background, occupation, marital status, etc., related to the decision that was made? Is the type of behavior responsible for the hospitalization related to the demand for a hearing or willingness to enter the hospital voluntarily? Do hospital-related factors, that occur after the patient is admitted, systematically influence a patient's decision to volunteer for hospitalization rather than demand a petition? Finally, do committed patients stay in the hospital longer?

Demographic Characteristics

The usual demographic characteristics of age, sex, education, ethnic background, marital status, occupation, area of residence, referral source, and means of support did not differ significantly (at the .05 level of confidence) between patients willing to sign a voluntary application and those for whom a petition was filed. There was, however, a difference in the household composition of the 2 groups. Nineteen percent of the voluntary group and only 4% of the in-

voluntary group came from households with non-relatives. At the same time, 8% of the involuntary group and 2% of the voluntary group came from institutions. Also, it was noted that 52% of the voluntary group and only 38% of the involuntary group had previous State Hospital experience. Additionally, no differences were noted in the number of previous incarcerations or in the number of previous hospital admissions. There is suggestion that patients lacking adequate support systems (living with non-relatives or from institutions) and patients with previous mental hospitalization are more willing to enter the hospital voluntarily.

Thus, the only pre-hospitalization characteristics that seem to be significantly related to whether patients are willing to enter the hospital voluntarily are the amount of family support available to them, their previous experience with mental hospitals and whether they enter from an institution.

Factors precipitating hospitalization

Analysis of the type of behavior responsible for emergency hospitalization suggests that certain types of precipitating behaviors are related to whether a patient is willing to accept hospitalization voluntarily. Patients who have demonstrated self-destructive acts comprised 41% of the voluntary group, in contrast to the involuntary group which contained 29% who committed self-destructive acts. Behavior described as psychotic was found in 49% of the voluntary patients and in 37% of the involuntary group.

TABLE 2.—Percentage of Voluntary and Petitioning Patients from Emergency Status on Variables Demonstrating Significant Differences.

VARIABLES	PERCENT OF VOLUNTARY PATIENT	PERCENT OF PETITIONING PATIENT	CHI SQUARE	DF	PROBABILITY
A. DEMOGRAPHIC CHARACTERISTICS					
1. Household Composition					
a. with non-relative	18.9	4.3	16.42	1	.0001
b. institution	1.8	8.4	4.51	1	.0336
2. Previous State Hospital	52.3	37.5	7.18	1	.0074
B. FACTORS PRECIPITATING HOSPITALIZATION					
1. Reason for Admission					
a. Danger to Self (Reason of Neglect)	58.3	70.9	6.02	1	.0141
b. Disruptive	61.2	78.5	12.90	1	.0003
2. Behavior					
a. Self-destructive	40.7	29.4	4.75	1	.0293
b. Non-conforming	35.0	59.6	21.25	1	.0001
c. Psychotic	48.6	36.6	4.95	1	.0261
d. Depression	36.4	59.2	18.19	1	.0001
3. Person Responsible			16.06	5	.0067
a. Family	32.8	28.4			
b. Law	25.4	38.1			
c. Friend	8.2	2.7			
d. Self	9.2	3.9			
e. Other	6.0	5.8			
f. Professional (Hospital)	17.9	21.0			
C. HOSPITAL ADMISSION FACTORS					
None	—	—	—	—	—

Involuntary admissions tended to be more frequently associated with disruptive behaviors (79% in contrast to 61% in the voluntary group), danger to self because of poor judgment or incapacity (71% in contrast to 58% in the voluntary group) and non-conforming behavior or depressive symptoms (both of which occur in almost 60% of the involuntary group, but in only 35 to 36% of the voluntary group). As indicated in Table 2, patients who required a petition more frequently had their hospitalization initiated by an officer of the law or a professional person rather than by a family member, friend, or by themselves.

These data suggest that a contributing factor in whether a patient willingly enters the hospital may be a function of the psychological stress he or she experiences, as reflected by the behavior precipitating emergency hospitalization. Patients with behavior that tends to be ego-alien and threatening, including self-destructive or psychotic behavior, seem more willing to accept hospitalization. Perhaps the structure and controls provided by the hospital are seen as positive to this group of patients. On the other hand, patients whose behavior is not as ego-threatening, including disruptive, non-conforming types of behavior, depressive symptoms, and behavior demonstrating incapacity to care properly for oneself, tend more frequently to resist hospitalization by requiring that a petition be filed.

### **Hospital-related factors**

The third set of variables investigated with respect to whether patients are willing to voluntarily enter the hospital, rather than request a petition for a hearing, concerned variables related to the hospital and events that transpired after the individual became a patient. Variables in this area were examined to determine if the hospital treatment programs contributed significantly to the patients' willingness to volunteer for continued hospital stay. The variables examined included the ward placement, the diagnosis given to the patient, the type of medication prescribed, the amount of risk attributed to the patient, ability to communicate effectively and relative degree of reality contact as measured by the orientation section of the mental status examination given at the time of arrival at the hospital. None of the variables related to the process of hospitalization showed significant difference.

Thus, as reflected by the data collected on these 407 patients, the hospital staff's perception of them and their subsequent care and treatment during the 48 hours of their emergency hospitalization do not provide the basis for accurately predicting which patients would volunteer for continued hospitalization and which would request a hearing before a judge and only accept hospitalization on the basis of an involuntary commitment.

### **Length of hospitalization**

An additional variable, examined in an attempt to differentiate the voluntary from the involuntary patients, concerned the length of time each was hospitalized prior to being discharged. Do involuntary patients remain hospitalized for longer periods than voluntary patients? At the time of data collection on these 407 patients, 9% of the voluntary group and 8% of the involuntary group were still hospitalized. The average length of hospitalization for those discharged was 41 days for the voluntary group and 48 days for the involuntary group. Statistical analysis of these differences indicates that they are not significant.

In summary, a detailed review of 407 emergency entries to the hospital suggests that a patient's willingness to volunteer for continued hospitalization is related to the degree of support available to him (or her) in the community, and to the degree to which the patient may be overwhelmed and threatened by his own self-destructive or psychotic behavior. As reflected by these data, there appears to be no significant relationship between what happens to a patient after he is hospitalized for a 48-hour emergency examination and his willingness to voluntarily accept hospitalization as a resolution of his emergency status. In addition, whether a patient elects to go voluntarily or requires a civil involuntary commitment does not appear to influence the length of time he will remain hospitalized. In either case, at least 85% were discharged within a 90-day period.

### **Summary and Discussion**

The major thrust of the 1976 revision of the Hawaii Mental Health Law was to afford greater protection for the constitutional rights of patients involuntarily committed for mental hospitalization. In discussing his decision responsible for revising the law, Judge King emphasized deprivation of liberty without due process as the key issue.

One of the most significant aspects of the revised law was the inclusion of "imminently dangerous to self or others" as a necessary criteria to justify non-consensual hospitalization. In addition, the revised law established a complex array of procedural due process required for involuntary commitment.

On the basis of the data collected on almost 2,000 patients entering the hospital under the revised statute and as presented in this paper, the following changes appear to be associated with these changes in the mental health statutes:

1. An overall decrease in the total number of patients entering the hospital. Although there are minor variations, this decline has been evident for the last 2 years.
2. A gradual increase in the proportion of pa-



tients entering for emergency examination and hospitalization. With increasing frequency, judges and psychiatrists consider they have probable cause to believe an individual meets criteria for emergency examination and hospitalization.

3. In spite of an increasing proportion of emergency admissions, the total percentage of voluntary patients has increased from approximately 45% prior to the revised law<sup>1</sup> to the 69% who consented to hospitalization within the more complex procedures provided by the revised statutes. This suggests that one result of the 1976 revision of the mental health law, including the more complex due process procedures and the specification of "imminently dangerous," has been an increase in the portion of patients who eventually enter the hospital because of a voluntary decision on their part.
4. The factors most frequently associated with a patient's willingness to consent to continued hospitalization following emergency admission include the degree of support he or she has in the community, previous association with the hospital and finally, the amount of psychic stress from poor control of self-destructive or psychotic behavior. There is no indication that the treatment received by the patients after entering the hospital is systematically or significantly related to their

willingness to volunteer for continued hospitalization.

5. Finally, and perhaps the more alarming aspect of the hospital statistics provided in this report, is the suggestion that the more restrictive criteria for involuntary commitment have served to delay hospitalization for some mentally disabled individuals until their disturbed behavior reaches criminal proportions. At that point, the penal code becomes a viable option for dealing with the disruptive behavior that was not amenable to civil procedures.

Our overall assessment of the revised statute is that it has had both positive and negative consequences. On the one hand, our statistics indicate that the more restrictive and complex criteria for non-consensual hospitalization may have resulted in fewer admissions, with a greater proportion of patients entering the hospital because of a voluntary decision on their part. On the other hand, our statistics suggest that the more complex and restrictive criteria may delay the hospitalization of some individuals until their behavior reaches criminal proportions. Perhaps any revision of mental health statutes necessarily must involve a trade-off between advantages to one group and disadvantages to another group. If this is true, it then becomes the responsibility of the legislature, the judiciary and the mental health professional to determine what degree of trade-off would be most appropriate.

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## Anglophilia—1978

CHARLES S. JUDD, M.D., *Honolulu*

● *The American continues to be attracted to Great Britain and Ireland, whether it be curiosity about his heritage and the background of many of his traditions, a respect for the sophistication of Londoners, or because of that special type of humour, the exponents of which are Alex Guinness and Peter Sellers.*

It was my good fortune to travel with my wife and with Dr. & Mrs. Thatcher Magoun of Kauai to Britain in July, and within moments of landing at Heathrow Airport, my perspective began to expand. It took an hour to collect our baggage, during which time I learned that it costs "two p" to use a pay telephone. I converted some dollars to pounds and "p" (pence), and called a hotel. "Two p or not two p," the process of putting through the call went smoothly.

### The Facade of London

Londoners are more relaxed than New Yorkers. Cars and taxis move rapidly, but with a politeness that shames some of our American behavior. The pedestrian has a directness and purpose, but does not appear as harrassed or driven as the city dweller in the U. S. I had heard that the Arabs had taken over London, but in point of fact, one sees very few "Arabs" on the streets. Perhaps their invasion is a little more "oily," and involves the selling of petroleum. In our hotel lobby, on the other hand, at least 60 to 70 per cent of the people seemed to be from the Middle East, Africa, Asia, and Europe, with a sprinkling of Canadians and Americans. When the foreign conversation seemed to inundate us, we "Hawaiians" would, to each other, use expressions such as "Waikiki no ka oi," "Haina ia mai ana ka puana," etc., in loud voices. This proved a great match for the alien tongues.

The "bobbies," other public servants, and taxi drivers were uniformly courteous and polite. In the Red Lion Pub on Crown Passage in Pall Mall, a businessman from Liverpool befriended us. Over a "pint of bitter," we found much common

ground in regard to our outlooks on daily living, motivation, and humour.

Prices in London are fairly high; \$55 a day for a double hotel room, \$15 for a filet of sole dinner, and \$60-72 for a good pair of shoes. Affluence is apparent; although Rolls-Royces are not ubiquitous, they are by no means uncommon.

As we travelled in the "tube," conversed with bus drivers, and mingled amid the throngs in such great monuments as St. Paul's Cathedral, we became ever more curious about the background of the people of Britain, and decided to dig into history by taking a trip down the Thames.

### Banks of the Thames as a Key to British History

We boarded our Thames River cruise boat at the Victoria Embankment on Sunday, July 9, about 1:00 p.m. Nearby are the Houses of Parliament and "Big Ben," and Westminster Abbey. As we passed under Waterloo Bridge downstream, we could see Royal Festival Hall on the south bank and Cleopatra's Needle on the north. The latter is an obelisk from Heliopolis dating to 1500 B.C., and was a gift from Egypt\* in 1878. The H.M.S. Discovery is permanently moored at the Embankment. This is the vessel that took Admiral Scott to Antarctica in 1901. A few blocks in on the north bank lie the beautiful gardens of Lincoln's Inn Fields, once a duelling ground, now surrounded by old houses—some designed by the architect Inigo Jones in 1640. Here also is the Royal College of Surgeons which houses the John Hunter collection of specimens, anatomical and pathological. Unfortunately, some of this was destroyed by the bombings of World War II. Next to the Fields is the Old Curiosity Shop, immortalized by Charles Dickens.

After passing under Blackfriars Bridge, we could see Old Bailey, the Central Criminal Court, on the site of the old Newgate Prison. Near this is



St. Paul's Cathedral, built by the architect Christopher Wren between 1675 and 1710. It has the second largest dome in the world. Behind the cathedral lies St. Bartholomew's Hospital, founded in 1123 outside the walls of the city by Rahere, an Augustinian friar who had made a pilgrimage to Rome. One can stand in the original chapel of the hospital and give greeting, vicariously, to some of the great clinicians who trod the wards in past centuries: William Harvey, John Hunter, Percival Pott, and others. Across the street from "Bart's" is the old Church of St. Bartholomew the Great, which houses the sepulchre of Rahere. From this church are distributed hot cross buns to poor widows on Good Friday.

On the south side of the river is Bankside, the site of amusement centers and theaters including, formerly, Shakespeare's Globe Theater. The Clink Prison, nearby, gave rise to the expression "in the Clink." It was eventually burned down by rioters in 1780. London Bridge is probably the site of a bridge since Roman times. One of the London Bridges, which was built in 1831, was recently dismantled and shipped, stone by stone, to Arizona, where it has been reconstructed. The new bridge, which we passed under, is made of steel. We soon saw Samuel Pepys' Pub, where this master of the documentary often held forth with his cronies. Then came the Tower of London, a medieval fortress, repository of the crown jewels, and prison of such figures as Anne Boleyn; Mary, Queen of Scots; Sir Walter Raleigh, and Rudolph Hess, some of whom entered by way of the Traitor's Gate which opens right on the river. Tower Bridge, adjacent, is impressive with its twin hydraulic arms. The H.M.S. Belfast, a heavy cruiser and monument to the British Navy, is moored nearby. It last saw service in the Korean War. We passed the London docks, the pub where Captain Kidd, the pirate, was apprehended, and saw lumber yards where huge hardwood tree trunks from western Africa were awaiting construction into furniture.

We finally docked at Greenwich, where time and longitude "begin," the site of the maritime observatory and museum. The "Queen's Cottage" is here, as well as the Cutty Sark, a vessel that once travelled over 300 miles a day using sails exclusively, and the Gypsy Moth IV, the 40-foot sailboat in which Captain Chichester circumnavigated the world. He was knighted by Queen Elizabeth II with the same saber that her namesake, Queen Elizabeth I, had used in knighting Sir Francis Drake.

Our introduction to British history took only 50 minutes, but opened up to us many vistas as we explored the remainder of London and went into the country outside of the city.

### **The Royal College of Physicians**

From July 9 to 13, 1978, the College conducted a meeting devoted to cardiology. The

first several papers honored William Harvey, a fellow of the College, on the occasion of the 400th anniversary of his birth. Professor Gweneth Whitteridge of Oxford spoke on some of her studies of old Harvey manuscripts, especially that of the *De Motu Cordis* of 1628 in which he propounded his concept of the circulation of the blood.

Professor R. V. Short of Edinburgh recited studies he had made on red and alder deer on the island of Rhum off the west coast of Scotland, to substantiate the observations on the gestation of embryos in similar deer that constituted the basis of Harvey's work, *De Generatione*, which appeared in 1647.

Up-to-date presentations of echocardiography and electrocardiography were made by such figures as Hugenholtz of Rotterdam and Krikler of London. Braunwald of Harvard spoke on the hemodynamics of heart failure and Guyton, the American physiologist, had the honor of giving the annual Harveian Oration on cardiovascular regulation.

Highlights of the meeting were a journey for participants to Folkestone on the coast of the English Channel, Harvey's birthplace, and a visit to the sessions and for tea by H.R.H. Prince Philip, the Duke of Edinburgh. The latter came to the meeting unobtrusively and without fanfare, spoke informally with many of the participants present, and gave the meeting just the right amount of dignity.

### **Wales**

After leaving Stratford-on-Avon, Shakespeare's birthplace, we drove 3 hours in a north-westerly direction and entered the rolling hills of Wales. The farmhouse of Mr. and Mrs. Bennett, where we spent the night, was on the edge of a huge green valley 20 miles long and 5 miles wide. We looked down on the peaceful meadows and fields of grass and oats, stone wall-enclosed pastures of sheep and cattle, and a small river and barge canal, their banks lined by oak trees. In the small town of Welchpool, we heard some mixed choral voices, singing in Gaelic. It could have been 1878, or even 1778.

### **Scotland**

We crossed the estuary of the Clyde, west of Glasgow, by taking the ferry from Gourrock to Dunoon. At Inverary we saw the stronghold of the Campbell clan, the castle of the Duke of Argyll, with its halberds, armor, and paintings by Gainsborough. Scottish games were being held on the grounds. The marching band of pipers, the sword dancing, and crowd of villagers and visitors, about 3,000, created a festive air. The hammer throw, shot put, races, and high jump were climaxed by the tossing of the caber—a huge log 20 feet long, weighing 84 pounds, which the Scotsman lifts by one end, balances a moment, and then flips forward, end over end.

Later that day we drove along the shores of Loch Lomond and ended up at Stirling Castle. Nearby is the bridge over the Forth River where the first great Scottish hero, William Wallace, in 1297 fought off the British invaders and won. The castle figured prominently in the history of the Stuarts; one of the last of that clan, "Bonnie Prince Charlie," tried unsuccessfully to make a comeback at Stirling to regain the English crown in 1745.

### Ireland—1978

This country is said to be 40 shades of green. Its pastoral fields display this color, as do the uniforms of the pretty flight attendants on its airline. I thought Aer Lingus might mean "a slip of the tongue," but gradually became used to those words as well as to Gaelic words on road signs, stores, as street names, and in the speech in some parts of the country. Having read Leon Uris' *Trinity*, I had no desire to visit Northern Ireland so we landed at Dublin. We were fortunate to enjoy the hospitality of the home of an Irish family the very night of our arrival. Their warm, spontaneous, and whole-hearted friendliness made us feel as if we were coming home.

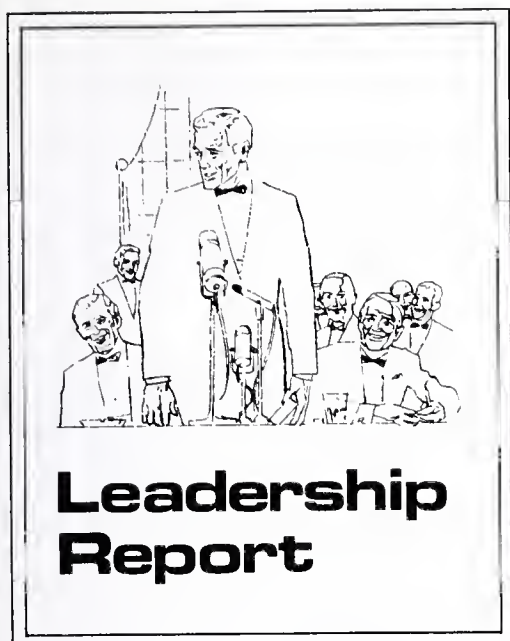
We slept every night at a "bed and breakfast" house. This is a private home where the family takes in overnight guests to supplement its income. The guests sleep in a regular bedroom and breakfast is taken very often right with the family. The charge is most reasonable, usually about £3.50 (\$7.00) per person per night. It gives the guest a cross-cultural appreciation of the people and is the antithesis of staying at an American-type hotel or motel. We selected "B and B" houses on side roads far from towns. The long twilight, extending until 10 or 10:30 p.m., put its blessing on the green fields, new-mown hay, sheep, and cattle; and as night ensued, the stillness was like that of our great western prairies.

Light, very faint, came again about 4:30 a.m. with a long dawn, often overcast without any

great blaze of color. The Irish are late risers; so we found the highways almost deserted as we got the car on the road in the early morning. An important maneuver when driving in Ireland is to remember to drive on the left side of the road. Only one in 14 persons has a car in Ireland, so hitch-hiking is a common practice. We picked up people several times a day—an old woman walking 4 or 5 miles with 2 heavy bags of groceries, a lady going to a doctor in a nearby town, a schoolboy who had been up all night, etc. The most charming passengers we had were 2 young ladies, Margaret and Deirdre O'Dwyer (approximate ages 20 and 21), who were going from Clonmel to Cork. Their immediate curiosity as to who we were and where we were going opened an animated conversation that lasted the whole 20 miles of our travel together. They were enthusiastic to learn about America and Hawaii, and expressed a desire to visit a great-aunt living in the Bronx. They evinced the usual keenness of their age in regard to singing and to "disco" music. But what was refreshing was their obvious love for their family life—six children in the family: 4 girls and 2 boys. These 2 girls, knowing their father's concern about their hitch-hiking, said they had promised to phone him after their arrival in Cork, their destination. Part of the family was soon to go off to Holland as members of a brass band on concert tour. Margaret was looking forward to a holiday in Italy. We took pictures of them, copies of which we later sent them.

The most impressive thing about the Irish as a group is their good looks. Their close family ties and intermarriage within the country have resulted in rosy-cheeked children, superb features in all ages, dark eyes and dark hair being prevalent—but of course other hues, especially red, existing. The good looks, coupled with the prevailing friendliness, make for fine people. Our country should be thankful indeed for its Irish infusion and heritage.





## Leadership Report

JON WON

March, 1979

**HMA Council Approved** a HMA Bureau of Planning & Research recommendation to apply for a subcontract from DOH for a Community Diabetes Demonstration Control Project. The 12-month project is initially for assessment and planning regarding baseline morbidity and mortality data, assessing care resources in the State, including treatment of diabetics and educational programs for providers of care, and for the diabetics and their families. Proposal will be rushed. Council also approved a continuing investigation into the development of an HMA-sponsored Independent Practitioner Association (IPA) which could be a component to supply physician services to one or more HMOs. In order to be able to offer the soloist the opportunity to participate in such a program, more development was felt necessary.

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**HMA Council Also Approved** joint venture with Bureau of Medical Economics in retaining a consultant to develop a Plan for Automation for HMA, HCMS, BME, and affiliated organizations. This has been necessary for some time. Arthur Young & Co. was awarded the contract.

\*\*\*\*

**HMA Community Health Care Committee** to formulate testimony on State Health Plan; hearings were held March 19-21, 1979. Names are now being accepted for nomination to a Statewide Health Coordinating Council (SHCC) and to Subarea Councils. Interested physicians, let us know if you are willing to serve.

\*\*\*\*

**HMA Council informed** that an attorney representing a clinical psychologist has asked HMA and Psychiatric Society to join in a lawsuit challenging the constitutionality of administrative search and seizure under Medicaid Fraud and Abuse provisions. HMA to confer with AMA and legal counsel.

**Health Bills** in State Legislature that are still active: amend definition of death provisions by removing requirement for neurosurgeon or neurologist to determine brain death—neighbor island physicians urged to contact their legislators to support this bill; HMA Legislative Committee to take issue of chiropractic reimbursement from prepaid health care programs under study; regarding rubella, HMA has agreed to support premarital rubella screening provided that followup and immunization of susceptible individuals is conducted by the Department of Health.

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**HMA has just received** loss figures (interim) from Argonaut Insurance Company for malpractice insurance since 1971. Argonaut to meet with HMA to discuss further.

\*\*\*\*

**Medicine on the National Scene:** The *Administration's Hospital Cost Containment bill* was introduced to Congress March 6th; it is expected to contain standby federal controls that would be triggered if average rate of hospital expenditures increases more than 9.7%, includes provision limiting capital expenditures costing more than \$150,000 to total of \$3 billion nationally. Hospital leaders and AMA feel 9.7% ceiling unnecessary and unworkable. White House has set up massive lobbying campaign to secure passage of bill. AMA is scheduled to present oral arguments in late April before the Federal Trade Commission in appeal of FTC ruling concerning physician advertising and the Principles of Medical Ethics. The ruling, which charges the AMA with restraining physician advertising and physician participation in certain health delivery systems, has not yet been approved by the full Commission. AMA willing to appeal to the U.S. Supreme Court, if necessary.

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**Sample Sets of surgical criteria** being developed by AMA, in conjunction with national specialty societies, under contract with DHEW. The sets designed for use in screening surgical cases to select those which should be subjected to peer review. Draft sets will be tested at seven PSRO sites.

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**Price arrangements** between pharmacists and the Texas Blue Shield are not exempt from federal antitrust laws, the U.S. Supreme Court has ruled. The decision could affect many similar agreements in other states, including Hawaii.

\*\*\*\*

**AMA Annual Meeting** for 1979 to be in Chicago, at the downtown Marriott Hotel, July 22-26. Interim meeting of the AMA House of Delegates in 1979 to be December 2-5 in Honolulu.

**Next HMA Council Meeting, April 6, 1979,** 5:30 p.m., at HMA offices. Agenda items to be discussed: Results from computer study; request from Community-based Cancer Control Program for possible subcontracts with HMA for technical training, technical information dissemination, prevention and detection activities, multidisciplinary management and followup care; also request from Cancer Control Council for submission of name of HMA representative to sit on Executive Committee of Cancer Control Council; legislative updates; reduced dues for physicians joining during their "first year" of practice. All HMA members welcome to attend, discuss, listen, etc. Please call HMA office to let us know.

\*\*\*\*

**HMA Leadership** gives special thanks to Senator Patricia Saiki, known as "Mrs. HMA" in the Legislative halls, for presenting a two-day workshop on the legislative process for nearly 50 physicians and spouses. Pat reviewed the steps involved in enacting legislation, talked about effective ways in which HMA physicians might become more involved in the process. Her inspirational messages must have gotten across because the attendance at the HMA Legislative Committee meeting a week later was "standing room only."

\*\*\*\*

**For your information:** Hawaii Chapter of AAFP honored a charter member, Dr. H. Q. Pang, at its annual meeting in late January, 1979, for his 50 years of active practice as a general and family physician. It was also noted that Dr. Pang makes 50 years as a member of Honolulu County Medical Society and HMA. The county societies and the HMA extend all its best wishes to Dr. pang for his involvement, participation, and his caring during all these years!

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**HMA member George Starbuck, M.D.,** Medical Director of the Children's Protective Service Center, was named the Honolulu Police Department's "Citizen of the Year" for 1978. The award carries many plaudits for Dr. Starbuck and cites him as a true credit to the medical profession with the best interest of the community always in mind. We congratulate Dr. Starbuck for his contribution to health, medicine, the medical profession, and the community!

\*\*\*\*

**Colby College, Waterville, Maine,** continuing to offer national seminars in continuing medical education each summer. It has been reaccredited by AMA to award Category I credit. Summer 1979, July through August, it is offering courses in 14 topics from 15 to 30 credit hours. Course topics include Allergy and Immunology, Emergency Medicine, Epilepsy, Pediatrics, Surgical Techniques, Hematology, Dermatology, Neurosurgery, Otolaryngology,

Ophthalmology, Nuclear Medicine, Obstetrics-Gynecology, Forensic Medicine, and Pulmonary Disease. Schedule available at HMA office.

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**Three (3) positions available** immediately at Waimea Clinic, Kauai; GP (FP), Internist, General Surgeon, to start immediately. Interested physicians call Dr. Robert Weiner, phone 335-3107 on Kauai.

\*\*\*\*

**Wanted:** General Practitioner to start immediately or within 30 to 60 days. Women and minority applicants encouraged. Salary negotiable. Interested physicians write to Kona Coast Medical Group, Inc., 75-5759 Hamilton Bldg., Suite 201, Kailua, Kona, Hawaii, 96740, Attention: Judith Bail, or phone 329-2766.

\*\*\*\*

**Labor Gears Up For Medical Bill Battle:** The word has gone out from George Meany's labor hierarchy that a nationalized health bill must be passed by the next Congress convening in January. "No social issue has a higher priority." Local labor organizations have been urged to take up the cudgels and beat on the doors of their congressmen demanding passage of the socialized medical bill designed by the AFL-CIO in collaboration with Senator Edward Kennedy.

It would seem then that practitioners of private medicine have an urgent need to communicate their feelings to their representatives in Congress; Senators Dan Inouye and Sparky Matsunaga as well as Representatives Cec Heftel and Dan Akaka.

Labor rank and file think compulsory nationalized medicine means they'd get it free. This is the great myth that must be dispelled by the intelligent presentation of the case against compulsory medicine. Above all, we need to impress on the public and on those physicians working for government directly and indirectly that not only will it not be free, it will cost more and they will get less service for more money. *U.S. News and World Report* says that the Carter-Kennedy nationalized medicine program would add another \$2,000 to your federal tax bill. We have little time to lose; Congress meets in January. Support HAMPAC and AMPAC.

Might be interesting to note some findings from two surveys conducted by the Gallup Organization on National Health Insurance:

- 53% of public feel strongly there is need for NHI—another 11% feel there is need but do not feel strongly.
- 40% of nation's physicians feel strongly there is need for NHI; another 13% feel there is some need—total of 53%.
- Majority of nation's physicians, including those who feel strongly about need for NHI, believe quality of medical care will get worse if NHI enacted.
- That rising costs dominate the public consciousness with respect to health care issues, as

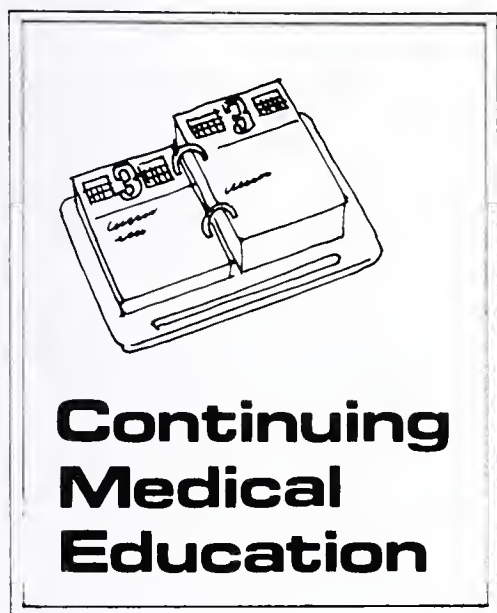


public, when asked on unprompted basis to name most important problems facing health care, 66% of the first mentions were on costs.

- Speakers representing the polling organizations pointed out that, while there is increasing demand for changes, there is no public consensus on what changes should be—They stressed *this opportunity for leadership by the medical profession.*

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**HMA Employees Offered Kaiser Foundation Health Plan.** HMA employees may now elect coverage either under HMSA Plan A or Kaiser Foundation Health Plan A effective January 1, 1979. Group coverage under either plan has been made available to all HMA employees serving HCMS, EMS, Tumor Registry, Physicians Exchange and to employees of the Bureau of Medical Economics.



## Continuing Medical Education

### CALENDAR OF ACCREDITED EVENTS—CATEGORY I

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

#### LOCAL ACCREDITED PROGRAMS

##### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.

7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.
9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.

##### Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

##### Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

##### Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
  2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
  3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
  4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
  5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

##### Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

##### Kuakini Medical Center

1. Visiting Professor Program
  2. Nephrology Conf., 4th Wed., ea. mnth. 8-9:00 a.m.
  3. Oncology Conf., every Thurs. 7:30-8:30 a.m.
  4. Surgical Conf., 1st, 2nd, & 3rd Fri., 1-2:00 p.m.
  5. Surg. M & M Conf., 4th Fri. 1-2:00 p.m.
  6. Ophthalmology Departmental Mtg., 1st Tues. ea. mnth. 1-2:00 p.m.
  7. G. I. Conf., 4th Tues., 8-9:00 a.m.
  8. Med. Mortality & Morbidity Conf., 4th Tues., 1-2:00 p.m.
- (Contact CME Dept.-Kuakini for further information)

##### Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd.—Telephone Task Force—3rd Tues. 12:15-1:15 p.m.

3. Dept. of Emergency Med., 3rd Mon., 7-8:00 a.m.
4. Family Practice Section—3rd Wed. 7-8:00 a.m.
5. Diagnostic Radiology—4th Tues., 12-1:00 p.m.

#### The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
- Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
- Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

#### St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Hematology Conf., 3rd Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
7. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

#### Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

#### Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

#### Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.  
HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30

p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.  
Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817  
At: Local Hospitals, Honolulu  
Type: 1, 1 hr./day, 1 day/mo. from 12 mos.  
Fee: None Methods: AV, O, Pan  
Dates: All yr., 12 hrs. instruction

## SPECIAL EVENTS

- |                   |  |
|-------------------|--|
| Apr. 8, 1979      | "Problems in Human Sexuality" 8:30 a.m.-4:55 p.m. 6½ hrs. Cat. 1 CME; 6½ hrs-P, AAFP. Held at: Ilikai Htl., Honolulu. Lederle Labs., HI Nurses Assoc. HMA, HI Pharm. Assoc. No Fee. Contact: CME Dept.-HMA (808) 536-7702.                             |
| Apr. 15-21, 1979  | Current Concepts in OB/GYN, Mem. Hosp. Med. Ctr. of Long Beach-Women's Hosp. 2801 Atlantic Ave., Long Beach, CA 90801. Cosponsor: U of CA, Irvine Ctr. for Health Educ. Held at Kauai Surf Htl, Lihue, 06766. 3 days, 24 hrs.                          |
| Apr. 21-28, 1979  | Emergency Med-1979 USC Sch. of Med. 2025 Zonal Ave. LA, CA 90033. Held at Royal Lahaina Htl., Maui. 5 days, 30 hrs.  |
| Apr. 21-28, 1979  | Diagnostic & Therapeutic Skills in Internal Med., USC Sch of Med., Div. of Postgrad., 2023 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.   |
| Apr. May 18, 1979 | Orthopedic Review, USC Sch of Med, Div of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.  |
| June 3-9, 1979    | Diving Med. U of H Schl of Med. 1960 E-W Rd., Honolulu 96822. Held at King Kamehameha, Kailua-Kona, HI. 6 days. Cat. I—25 hrs. Contact: CCECS, UH, 2530 Dole St., Honolulu 96822.  |
| June 9-16, 1979   | Radiology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Htl, Kamuela. 5 days, 30 hrs.  |
| June 14-20, 1979  | "Patient Learning Through Effective Use of Media"—1979 Phys. Seminar on Patient Ed.-20 hrs. Cat. I CME. Co-sponsor HMA. To be held at the Kuilima Hyatt Resort Htl. Contact: Media Institute, S 607 1833 Kalakaua Ave., Hono. 96815 or (808) 955-5908. |
| June 18-22, 1979  | Comparative Psychotherapies, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina Htl, Maui. 5 days, 30 hrs.   |
| June 23-30, 1979  | Manipulative Med. USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Sheraton-Waikiki, Honolulu. 5 days, 30 hrs.   |
| Aug. 4-11, 1979   | Ophthalmology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.  |
| Aug. 8-22, 1979   | 22nd Annual Postgrad Refresher Course, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Cosponsor: U of HI. Held: Honolulu, Maui & Kona. 39 hrs.   |
| Sept. 9-17, 1979  | Practical Management of Anesthetic Problems, USC Sch of Med., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 31¼ hrs.  |
| Oct. 9-12, 1979   | 123rd Annual Convention-HMA/AMA Regional Mtg. Ilikai Htl. Honolulu. 5 days. Contact: HMA Office (808) 536-7702.  |



OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.

ANNOUNCEMENT

January 12-18, 1980

15th International Surg. Congress—(10 Surg. Spec.) Cat. I—20 hrs. Held at Sheraton Waikiki, Honolulu, Creative Assoc. Chgo, IL. Contact: Pan Pac. Office—236 Alex Young Bldg. Honolulu or Charlotte (808) 536-4911.



Teaming With Business in a Common Cause

Last November an important American said in a speech deploring federal over-regulation and "Big Brother government":

"Will our people . . . be tempted by 'quick cures' to major problems through government action on symptoms . . . ?"

The speaker continued, "A majority of Americans believe the cost of regulation outweighs its benefits. A majority also believe government has become too paternal in trying to protect people from their own actions or inactions . . .

"Our challenge then is to recognize this new public mood as an opportunity to rebuild American faith in the free market principles that are the source of the strength and durability of the American way of life."

Who made these remarks to the Rotary Club of Chicago? A medical spokesman? One well could have, in view of such actions as the Federal Trade Commission attacks on physician-advertising principles and medical-school accreditation procedures. And in view of the clouded legislation that becomes stormy regulation—as in the case of the Health Planning Act of 1974.

But no, the speaker was William B. Johnson, chairman and chief executive officer of a large conglomerate, IC Industries, Inc.

What he said reflects the identity of interest—including public interest—between medicine and business.

A startling example of government self-interest versus medicine, industry (specifically the pharmaceutical), and the public was HEW's January firing of Norman Latker as its chief patent counsel after 22 years of federal service.

Latker had testified to Congress that HEW was delaying the release of potentially life-saving drugs. The *Chicago Tribune* quoted him, "The worst thing I could have done as HEW might see it was to tell the truth . . ."

The AMA also has deplored the delays in the approval and distribution of potentially beneficial drugs.

Drug regulation is one of the key issues faced by the new Congress. Another that affects medicine, industry, and the public is health-care cost containment—with the threat of federal controls that could ultimately result in rationing of care.

Cost containment is an area in which medicine and industry have been cooperating and must further cooperate. Industry was represented on the AMA-sponsored National Commission on the Cost of Medical Care, which (in the spirit of Mr. Johnson's "free market principles") stressed marketplace choice in health coverage. Industry also has an important role in the Voluntary Effort to curb the cost rise. And, AMA representatives have been talking to corporate boards of trustees on the cost problem and the profession's approaches.

Doctors in each state and locality should tell business (and the public) what our federation—the AMA—is doing about costs and other concerns, and invite joint voluntary action as opposed to federal hyperactivity.

There Must Be A Better Way

The recent attempts at medical decision-making in the legislature were a pretty sad spectacle.

Our lawmakers really aren't interested in adjudicating philosophical issues regarding informed consent of psychotic patients, any more than they are able to arbitrate ugly disputes among professionals over the merits of convulsive therapy.

The risk of optometrists' precipitating acute glaucoma was lost on legislators unable to grasp the mechanics of pupillary block. More subtle distinctions, such as reasons for discrepancy between the number of adverse drug reports and the frequency of adverse drug reactions, or the distinction between detection (by signs and symptoms) and actual diagnosis, were often simply incomprehensible to these laymen.

To our lawmakers' credit, when faced with mountains of complex and seemingly paradoxical data, they "decided not to decide." By sending medical imponderables "out for further study," the committee chairmen spared themselves the agony of decision and possible error, and chose the safety of the status quo.

But one wonders whether the Legislative Reference Bureau can shed much light on abstract and technical issues, given the multiple demands on its minimal budget. It is not clear just who *can* help, but it is clearly unfair to ask our legislators to make quick decisions on controversial scientific issues, especially when these involve matters of public health and safety.

Debate over drugs and medical treatment simply doesn't belong in the Capitol. There is not the time nor expertise for valid decision-making, and it is pathetic to see professionals arguing in the public circus.

We need a forum where interested parties (professional groups, licensing boards, the Health Department, etc.) can convene to testify and to debate applicable health bills before a qualified, impartial panel of scientific referees, which would then deliberate, and perhaps arbitrate, and finally present its recommendations to the following Legislature. It wouldn't be perfect, but such a Health Sciences Advisory Board would spare us the present painful spectacle. There must be a better way.

J.M.C.



**Friday, December 8, 1978**

**5:30 p.m.**

**HMA CONFERENCE ROOM**

**PRESENT:**

Drs. Goto, Bell, Hindle, Hanlon, Dang, Catts, Walsh, Stodd, Couch, Bruce, Cahill, Fong, Roth, Lafferty, Fu, Wigle, Magoun and Mrs. Yim, Dr. Sia, Dr. Simmons and Mr. V. Thomas Rice. HMA Staff present were Mr. Won, Mr. Leineweber, Mr. Ontai, Mr. Saranchock, Mr. Ajifu, Mrs. Chang, Mrs. Young, Mrs. Wong, and Mrs. Kendro.

**MINUTES:**

The minutes of the November 3 meeting were approved as circulated.

**TREASURER:**

The October financial statements were reviewed in detail and approved subject to audit.

## REPORTS OF THE COMMITTEES AND COMMISSIONS

*A. Cancer Commission:* Dr. Drake Will has accepted the chairmanship of the Cancer Commission and letters have been sent to the Cancer Society, Department of Health and University of Hawaii calling for nominations to replace those whose terms have expired on the Cancer Commission. A meeting of the Executive Committee with the Department of Health was held and it was agreed that Dr. Will be given two months to assess the status of the Cancer Commission. Dr. Goto noted that a letter had been received from UH President Fujio Matsuda regarding Council action that the Tumor Registry will not be moved to the new Cancer Center building.

*B. Medical Education:* Dr. Bruce briefly reviewed the report circulated to the Council regarding two meetings on CME held on the mainland. She also reported that a meeting of 10 of the 14 organizations accredited to offer CME programs was held and it was unanimously agreed that the HMA should continue to be the central recordkeeping institution for the state.

*C. Ad Hoc Committee on Child Health:* Dr. Sia reported that the ad hoc committee had completed its work on a Child Health Plan for the state. This plan will be presented to SHCC and the SubArea Councils and hopefully will be included in the State Health Plan.



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The Council reviewed the priorities of the plan and agreed to accept the plan as presented.

*D. Health Services and Care:* The Health Manpower Committee has been asked to develop position papers on Physician's Assistants and Nurse Practitioners. They will also meet with the nurses Joint Practice Committee.

Mr. Won noted some of the problems being faced by the Medical Arts Clinic in the Certificate of Need process. It was recommended that the HMA support the Clinic in their request for a CON. It was also noted that the present law defines clinics and medical centers as "organized ambulatory care facilities" and thus subject to CON rules. A meeting will be held to determine whether the law can be amended to exempt physician's offices from this process.

*E. EMS:* Dr. Dang reported that the contract negotiations have been worked out and HMA will receive quarterly allotments.

*F. Legislation:* The Legislative Committee is planning a workshop for the committee, as well as others who will be involved in the Legislative process in 1979. The Committee recommends that Kazuhisa Abe be retained as legislative counsel in 1979.

**ACTION:**

**The recommendation to retain Mr. Abe as HMA legislative counsel in 1979 was approved.**

*G. Public Health:* Dr. Fu reported that he and Dr. Kuboyama met with the Director of Health to discuss rubella testing as a part of premarital examinations. It was agreed that a possible approach to identifying those who are susceptible might be done in the marriage license bureau. The Department of Health will look into this possibility.

*H. Report of the County Medical Societies:* Maui County President Stodd reported that they had met with a nurse from the Maui Community College who spoke on the nursing programs at the college and the fact that by 1985 all nurses will be required to have a B.S. degree which will eliminate the programs at community colleges. It is recommended that the HMA go on record in support of multiple levels of entry into the field of nursing. The Council approved the recommendation. Kauai County President reported that they have had good attendance at their meetings and it appears that many of the Kauai County physicians will again join organized medicine. Dr. Wigle from Hawaii County extended an official invitation to the HMA officers to visit their society and asked for assistance in helping with their declining membership problems.

*I. Other:* It was reported that the AMA has given considerable support to the HMA in the area of membership development. They will assist the association in a membership campaign over the next three months.

**UNFINISHED BUSINESS:**

A letter was received asking for HMA support for the 9% Solution Conference to be held on Kauai in early January. HMA was an original sponsor of the Conference and it was requested that they contribute \$700 to the '79 Conference. Members of the Council agreed to support the 9% Solution but asked that they be provided with a breakdown of the funds previously committed by the HMA. Dr. Felix Lafferty, Dr. George Mills and Mrs. Becky Kendro will attend the Kauai Conference.

**NEW BUSINESS:**

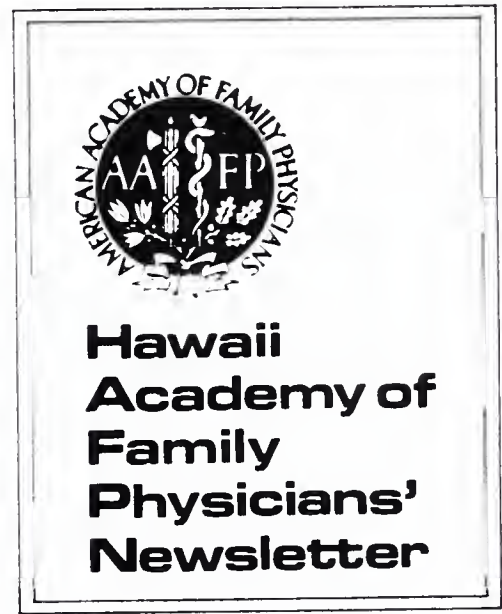
*A. Report of the AMA Delegate:* Dr. Chinn sent a report of the AMA Interim Meeting of the House of Delegates outlining the major issues of discussion. Mr. Won reviewed the primary issues which included chiropractic, national health insurance, and CME Standards. A full report will be presented at the January Council meeting.

*B. Report of the Executive Director:* Mr. Won reported that the staff has been investigating the feasibility of utilizing data or word processing equipment for HMA operations. In view of the need for increased information, the enormous accounting operations now being done manually, the impact of CME records, etc. it is believed that the needs of the membership can best be served by mechanization of some of the administration activities. More research and data gathering will take place prior to any recommendations to the Council.

*C.* It was noted that it has been the custom to give HMA employees a Christmas bonus. It was voted to approve a 2% bonus for HMA staff.

**ADJOURNMENT:**

The meeting adjourned at 8:45 p.m.



J. I. FREDERICK REPPUN, M.D.

**New Members**—Returning as a member, and this time as a Resident Affiliate is **Benedict M. Diniega**, who is a Resident in Family Practice at the Kaiser Foundation Hospital in Waikiki. Welcome back! **David Hobbs** is a new Active member practicing in Waianae. **Lt. Col. Robert Todd** is a new Active member of the Hawaii Chapter, but actually a long-time member of the Military Chapter. Welcome all!

**News of Members**—A recent meeting between members of HMA's committees and the DSSH Recipients Ass'n found **Rodman Miller** as chairman, with members **Tom Cahill** and **Fred Reppun** joining Roy Kuboyama, Lee Simmons, Bob Clingan and others of HMA. **George Monlux** has been granted one year's leave of absence to practice in Alaska. Assigned to committee chairmanships by the HAFP Council at its February meeting were: **Glenn Stahl** to Health Care Services, **Mike Hayes** to Education, **Tom Cahill** to Legislative, **Jean Reppun** to Membership, and **Fred Reppun** to Constitution & ByLaws.

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**Membership**—as of the end of 1978, our total membership was 148, of which 70 are Active, 4 are Active Exempt (old category), 4 are Practicing Affiliate, 16 are Life, 6 are Inactive, 34 are Students and 14 are Resident Affiliate.

**State Officers Conference**—The Annual SOC in Kansas City will take place on 26-29 April. A.A.F.P. will furnish roundtrip airfare to one representative from Hawaii, but will charge a registration fee! Included is a one-day Infectious Disease Conference put on by the U of Kansas Medical School, which is always excellent. Either **Dave Swanson** or **Jim Tsuji** will be attending.

**CMER**—Computerized Medical Education Records indicates that participation by Hawaii members has risen from 55% of our Active members in 1977 to 60% in 1978, which places Hawaii in 11th position out of 47 chapters in the program. CMER is working hard to work out all the bugs in the program. Computerized or not, accreditation depends on the individual member keeping track of each session attended and recording AT THE TIME whether it is "P" or "E".

**CME**—The Chapter has been assured that the 22nd Annual Postgraduate Refresher Course in August put on by USC—UH—TAMC does qualify for "P" credit. The next ABFP Recertification Examination takes place on 6 July in several centers on the Mainland. Candidates may be interested in "A Review of New Developments since 1973", an intensive 3-day seminar, put on by the U of Texas Health Science Center in San Antonio 1 to 3 June 1979. The registration fee is \$160. Members can pick up 14 "P" in Spokane Washington on 11 and 12 May 1979 for \$90. The Lederle Symposium sponsored by HMA on Sunday 8 April at the Ilikai on Human Sexuality has been approved by AAFP as "P."



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FRANCIS FUKUNAGA, M.D.

## Glycosylated Hemoglobin In Diabetes Mellitus

Glycosylated hemoglobins or "fast fraction" hemoglobins are modifications of the normal Hb A by the attachment of carbohydrate moieties. This attachment to Hb A occurs throughout the life span of the mature red cells. These fast fractions are called Hb A<sub>1a</sub>, A<sub>1b</sub>, and A<sub>1c</sub> and comprise approximately 1.5, 0.8 and 6% of the total hemoglobin in the adult red blood cell.

The Hb A<sub>1c</sub> is of interest because it increases two to threefold in diabetic patients. The attachment of glucose to the hemoglobin A depends upon the level of circulating blood glucose and the cumulative level of Hb A<sub>1c</sub> is directly proportional to the time averaged blood glucose level over the last 120 days.<sup>1,2</sup> Whereas glucose is rapidly cleared from the body, Hb A<sub>1c</sub> remains elevated for three to four weeks after blood and urine levels have returned to normal. The Hb A<sub>1c</sub> values therefore are of greatest help in assessing blood glucose levels of diabetic patients between visits to their physician. Diabetic control is usually assessed by determining the fasting or postprandial blood glucose but these often are not representative of the daily mean blood glucose levels. Even the diagnosis of diabetes mellitus may be as troublesome as assessing the degree of diabetic control. Glucose values vary with time and also depend upon the method used. Glucose tolerance tests have been shown not to be reproducible<sup>3</sup> and there is still controversy even among experts as to what constitutes an abnormal glucose tolerance test.<sup>4</sup>

A single determination of glycosylated hemoglobin can substitute for multiple blood glucose determinations and the test may be done at any time of the day since there is no immediate change following meals or activity. It takes about two to four weeks for a change of Hb A<sub>1c</sub> in response to good or lack of control. Normal controls and diabetics can be separated into groups based upon their Hb A<sub>1c</sub> values and the diabetics can be subdivided into two subgroups. The diet controlled diabetics have lower values than the insulin dependent diabetics.

Because the Hb A<sub>1c</sub> is a modification of hemoglobin A, its determination in diabetics is not helpful in patients with sickle cell anemia and other hemoglobinopathies. Abnormal levels of hemoglobin F cause in-

creased values for glycosylated hemoglobin. Patients with shortened red cell survival due to hemolysis or bleeding have lower than expected values while those with lengthened survival as in post-splenectomy patients have higher than usual values. The hemoglobin level and reticulocyte count should therefore be done to rule out a shortened red cell survival.

There is no need to measure individual components because the level of Hb A<sub>1c</sub> correlates very well with the total glycosylated hemoglobin ( $r=1.0$ ).<sup>5</sup> The methods in use in routine laboratories are either by column chromatography or high pressure liquid chromatography.

#### REFERENCES

1. Gabbay KH; *et al*: Glycosylated Hemoglobin and Long-Term Blood Glucose Control in Diabetes Mellitus, *J Clin Endocrinol and Metab* 44:859-864, 1977.
2. Gonen B, *et al*: Haemoglobin A<sub>1</sub>: An Indicator of the Metabolic Control of Diabetic Patients, *Lancet* 2: 734-736, 1977.
3. McDonald GW, *et al*: Reproducibility of the Oral Glucose Tolerance Test, *Diabetes* 14:473-480, 1965.
4. West KM: Substantial differences in the diagnostic criteria used by diabetes experts. *Diabetes* 24:614-644, 1975.
5. Cole RA, *et al*: A Rapid Method for the Determination of Glycosylated Hemoglobins using High Pressure Liquid Chromatography, *Metab.* 27:289-301, 1978.



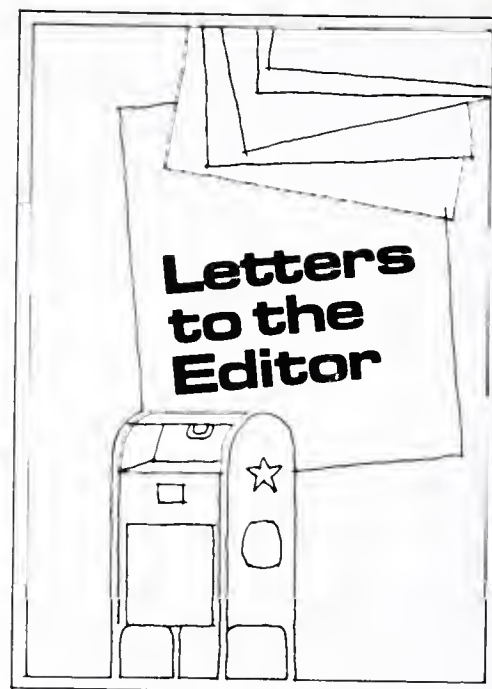
#### Current Medical Diagnosis & Treatment

Krupp MA, Chatton MJ (eds.). Los Altos, Lange, 1979. 1130 pp. Price, \$18.

"Current" means 1978-79 in this annually updated soft-cover compendium of general medicine. No family practitioner, and hardly any internist, can afford not to have it at his or her fingertips. As a desktop reference it can hardly be touched for currency and inexpensiveness, as well as authority, for almost every author is a recognized authority on the faculty at Stanford or the University of California.

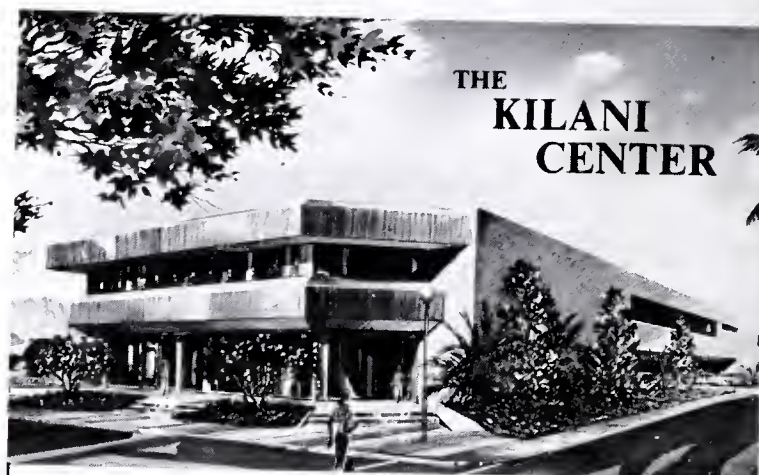
If the other sections are only half as authoritative as that on the skin and its appendages by Rees B. Rees, professor of dermatology at the University of California, then you can rely on the entire book, and a most useful desk-top reference it would surely be.

HARRY L. ARNOLD, JR., M.D.



To the Editor:

I am writing to inform you of both my dismay and displeasure over what I read under "Claude Carver's Witticism" in the November issue of your journal (1978). Racial slurs (a base "Polish joke", a denigration of the American Indian, and the demeaning of the American Southerner) have no place in American letters, least of all in a publication of a medical association. Claude Carver's "witticism" is a disgrace and you and your journal owe a public apology to those groups singled out in your column for calumny.



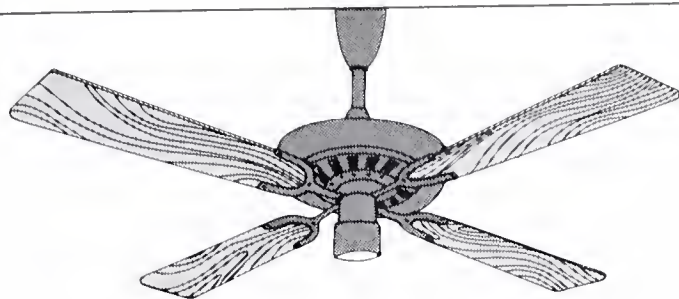
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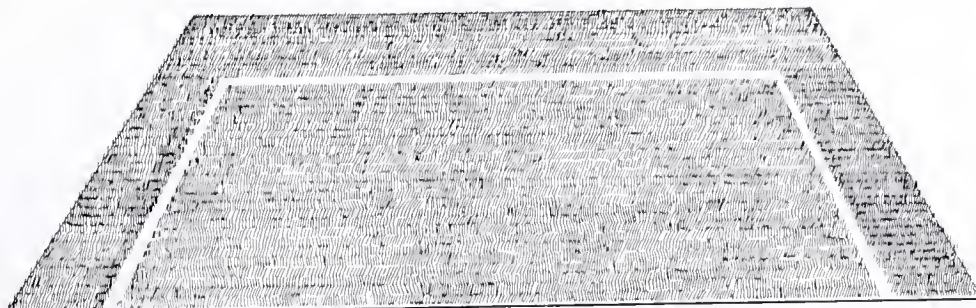
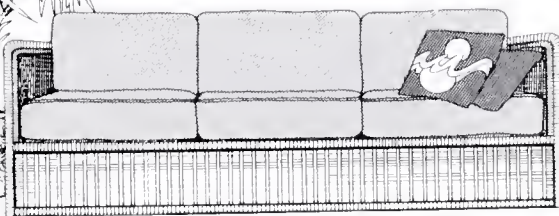
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I hope that you will print this letter in your journal and that, in future, you will exercise wisdom and judgment and sensitivity in matters like this.

EDWIN P. KULAWIEC, PHD  
Associate Professor of Education  
George Washington University

copy to: Joseph A. Califano  
Secretary, H E W  
200 Independence Avenue SW  
Washington, D.C.

*We do apologize for the offensive "Polish joke". We cannot agree that the Indian story constituted a "denigration" of the American Indian, however—though it too deserves an apology because it was incorrectly told. Actually, the squaws were sitting on the various hides, and the snapper should have read "Because the squaw on the hippopotamus is equal to the sons of the squaws on the other two hides." I am mildly surprised that you thought the third joke demeaned the American Southerner. I didn't think so (though this material was not seen by me prior to publication), and so far no Southerner has made any objection to it. Ethnic jokes are best when told by a member of the victim's own ethnic group, but they are not as grossly offensive, in my opinion, as you believe them to be. My many Polish friends are mostly of my mind.*

HARRY L. ARNOLD, JR., M.D.  
Editor

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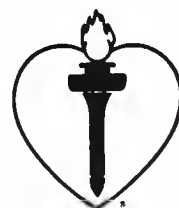
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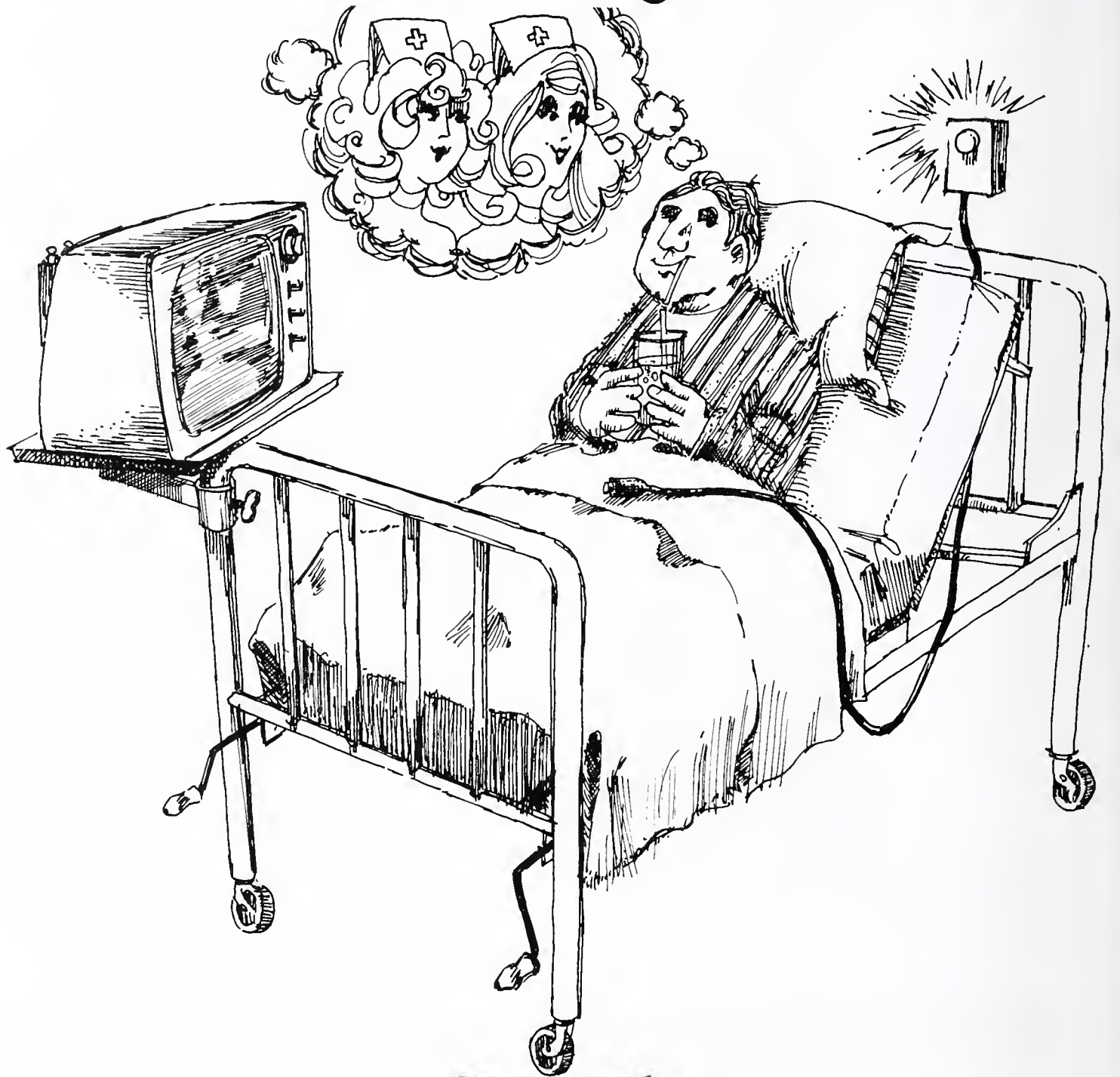
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APRIL, 1979  
VOL. 38, NO. 4

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**Indications and Usage:** For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. **Note:** The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A  $\beta$ -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura; hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum

sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

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60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

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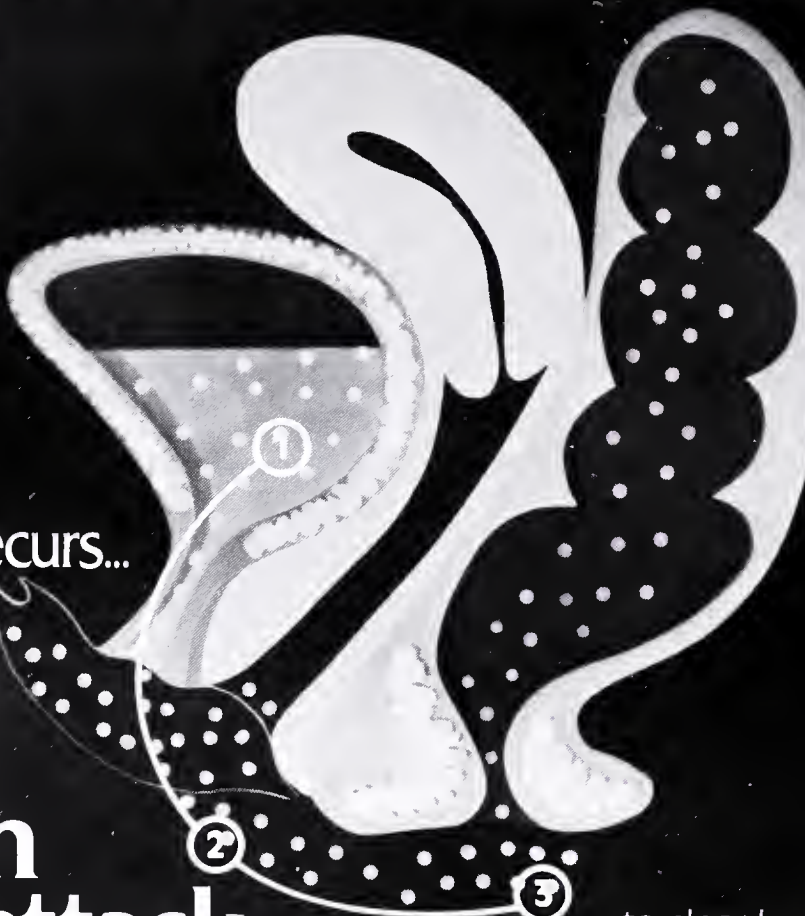
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**Reference:** Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N. Y. 1969.



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# When to Discharge a Patient Surviving Acute Myocardial Infarction

R.M. WORTH, M.D.; D.J.G. FERGUSON, M.D.; J.H.C. KIM, M.D.;  
E.L. CHESNE, M.D.; K. KURAMOTO, M.D.; A.D. MORRIS, M.D., and  
I. RAHMAN, M.D., Honolulu

● *The records in 4 Honolulu community hospitals were searched to identify patients with discharge diagnosis of acute myocardial infarction (AMI) who had undergone continuous ECG monitoring for at least 4 days and who had survived at least to the 5th hospital day.*

*The 590 cases were divided into 4 groups, according to whether or not strict diagnostic criteria for AMI were met and whether or not there had been a previous admission for AMI. The groups thus identified were: (1) Definite first AMI (359 cases); (2) Probable first AMI (101); (3) Definite recurrent AMI (96); and (4) Probable recurrent AMI (34). Complications were absent in about half of both "definite" groups and in more than half of the "probable" groups, giving a total of 319 subjects without complications.*

*When complications did occur, they commenced within the first 5 days among first AMI and within the first 8 days among recurrent AMI patients.*

*This study confirms a previous report from Duke University, indicating the safety of early hospital discharge (by the 7th day) for patients with a first AMI who have had no complications during 5 days of continuous ECG and nurse monitoring. It suggests, however, that greater caution is indicated for those who have suffered a prior AMI and that in this group, observation for complications should be continued through the 8th hospital day.*

Arteriosclerotic heart disease (ASHD) is a major cause of premature death in industrial societies, and population-based prospective studies have shown that a majority of such deaths occur "suddenly"—less than 24 hours after the onset of the symptoms of acute myocardial infarction (AMI).<sup>1-4</sup> The proportion of "sudden" deaths is somewhat higher among men and among those with a prior diagnosis of ASHD. It

appears that about 50-60% of these "sudden" deaths occur within the first hour after the onset of AMI symptoms.<sup>1-5</sup> Roughly 65% of deaths from AMI occur during a time by which the patient has had a good chance of reaching a hospital. The focus of the development of Coronary Care Units (CCU) has been to try to reduce the case fatality rate among those who are hospitalized with AMI. A major challenge is to use the expensive armamentarium of the general hospital in the most cost-effective way that is consistent with the safety of the patient.

Both British and American studies<sup>6, 7</sup> have indicated that prolonged hospitalization does not offer any advantage to most AMI patients without complications. Recent studies from the Duke University Cardiology Division<sup>8, 9</sup> suggest that 5 days of careful monitoring is enough to identify a subset of AMI cases who can safely be discharged on the 7th day for ambulatory supervision, with very significant savings of cost and without any increased risk of complications during the following 6 months of observation. The liability nightmare, of course, is for the patient to drop dead suddenly as he is on his way home after such an "early" discharge.

Since patients admitted to University hospitals may differ from those admitted to community hospitals and since the intensity of surveillance and recording may be at a lower level in community hospitals, the retrospective part of the Duke studies was replicated in 4 general community hospitals\* in Honolulu, Hawaii to determine whether the Duke findings would be valid in these more typical settings and in a different population.

## Methods

This was a retrospective study to test the hypothesis that those AMI cases not experiencing any of a specified set of complications within 108 hours of hospital admission for CCU or similar continuous monitoring will do well during the remainder of that hospitalization. This study did not address the question of post-hospital survival.

The data were tabulated separately for those with and without a previous hospitalization for AMI.

The criteria for inclusion in this study were all of the following:

1) Having been coded as AMI (410 on the primary discharge diagnostic index).

2) Being admitted directly into a continuous monitoring environment and kept in hospital for at least 4 days (all early deaths and the few "false alarm" early discharges\* were thus excluded).

3) Not being transferred to another institution within 10 days (difficulty in linking records for adequate observation).

The diagnostic indices at Kaiser Hospital (serving a population of about 100,000 Health Plan subscribers) and at Straub Clinic and Hospital (a 90-doctor fee-for-service group practice) were searched from January 1974 through the most recent monthly diagnostic index available in 1978. Because of budgetary limitations, the samples from Kuakini and Queen's (both general community hospitals with more than 100 staff physicians) were restricted to patients from a small number of volunteer internists, with the discharge dates limited to 1977 and 1978.

These records were abstracted by 2 students trained and supervised by the first author, who did independent duplicate abstracting on a sample of records from each hospital periodically during the abstracting period (June-August, 1978). In order to avoid sample selection bias or abstracting bias, the abstractors and the record room personnel with whom they worked were kept ignorant of the hypothesis being tested. The detected error rate was 2-3%, consisting principally of missed early complications, particularly sinus tachycardia, which was occasionally not recorded in consistent locations in the medical records.

The abstract sheets were designed to describe the patient demographically and by a limited cardiovascular history, to validate the diagnosis of AMI,\*\* and to describe and locate in time the levels of care and any complications encountered during the hospitalization.

The criteria for complications were those used in the Duke study, but made more explicit in order to facilitate accurate abstracting:

1) Low blood pressure

a. systolic pressure <90 recorded twice at least 30 minutes apart, or

b. systolic pressure <100 and urinary output <20ml/hour over a period of at least 2 hours, or

c. use of sympathomimetic agents to maintain blood pressure.

2) Sinus tachycardia: rate >100 recorded twice at least 2 hours apart, with the patient at rest.

3) Extension of MI: using the same ECG criteria as upon admission, but occurring after the beginning of evolution; plus a secondary rise in CK.

4) Ventricular tachycardia: a cluster of more than three premature ventricular contractions in a row.

5) Ventricular fibrillation

6) Atrial arrhythmia: supraventricular tachycardia, atrial fibrillation or flutter.

7) Conduction block: 2nd or 3rd degree.

## Results

Table 1 describes the age, sex, and hospital of the 590 subjects who met our sampling criteria.

Table 2 shows the 460 cases who had no history of prior admission for AMI. Of these, 359 (78%) met our criteria for the diagnosis of AMI and are defined as "definite," while 101 failed to do so and are defined as "probable." In both groups our hypothesis is supported.\*\*\* The first occurrence of one of the specified complications was never observed later than 108 hours after admission to monitoring. Fatalities occurred only among those who had had one of those complications within the first 108 hours.

In the "definite" group, about half developed no complications, as was the case in the Duke study. In the "probable" group, however, the uncomplicated cases make up about 70% of the total, probably reflecting a high proportion of subjects with mild or no AMI.

\*Such cases were quite rare in this study, accounting for fewer than 5% of CCU bed-days.

\*\*Validation of the diagnosis was based in about 95% of the cases on review by one of the authors of the original ECG tracings, plus enzyme criteria. The criteria were similar to those used at Duke. A case without history of a previous MI had to have a Q-wave meeting the Belsky, Kagan, Syme criteria<sup>10</sup> or typical AMI S-T, T evolution, plus at least one of the enzyme criteria (see below). Those with a previous MI history had to demonstrate either a new Q-wave or show typical S-T, T evolution, plus at least one of the enzyme criteria. Those cases without a review of the ECG had to meet at least 2 of the enzyme criteria:

1) Total creatine kinase (CK) rising to at least 150% of the upper limits of normal for that laboratory, followed by a fall to below 75% of the peak value within 48 hours thereafter.

2) Presence of the MB ("myocardial") band of CK.

3) Reversal of the usual LDH isoenzyme ratio (1<2).

\*\*\*It should be noted that in a few fatal cases the premonitory complication consisted only of a sinus tachycardia within a day or 2 after admission, and in some the onset of complications was as late as the 5th day.



TABLE 1.—Distribution of 590 eligible acute myocardial infarction\* discharges by hospital, age, and sex—Honolulu, Hawaii 1974-1978.

HOSPITAL	SEX	AGE OF PATIENT			(MEAN)	TOTALS
		<50	50-69	70+		
Kaiser	F	15	48	15	(59)	78
	M	51	166	27	(57)	244
						322
Kuakini	F	1	2	3	(65)	6
	M	3	6	6	(62)	15
						21**
Queen's	F	0	0	0	(—)	0
	M	3	7	0	(53)	10
						10**
Straub	F	3	33	29	(65)	65
	M	41	100	31	(58)	172
						237
Totals	F	19	83	47		149
	M	98	279	64		441
						590

\*See text for inclusion/exclusion criteria.

\*\*Limited samples at Kuakini and Queen's (see text).

TABLE 2.—Distribution of 460 first acute myocardial infarction cases by certainty of diagnosis, occurrence of complications, and outcome. Honolulu, 1974-1978.

DIAGNOSTIC CRITERIA	COMPLICATIONS 1ST APPEARED	OUTCOME		TOTALS
		DISCHARGED ALIVE	HOSPITAL DEATH	
Definite AMI	none	182	0	182
	<108 hours	162	15	177
	108+ hours	0	0	0
				359
Probable AMI	none	71	0	71
	<108 hours	26	4	30
	108+ hours	0	0	0
				101
		441	19	460

TABLE 3.—Distribution of 130 recurrent acute myocardial infarction cases by certainty of diagnosis, occurrence of complications, and outcome. Honolulu, 1974-1978.

DIAGNOSTIC CRITERIA	COMPLICATIONS 1ST APPEARED	OUTCOME		TOTALS
		DISCHARGED ALIVE	HOSPITAL DEATH	
Definite AMI	none	47	0	47
	<108 hours	40	5	45
	day 6-8	1	3	4
	day 9+	0	0	0
				96
Probable AMI	none	19	0	19
	<108 hours	14	1	15
	day 6-8	0	0	0
	day 9+	0	0	0
		121	9	130

Table 3 is a similar distribution of the 130 cases who had had a previous admission for an AMI. Among the 96 definite AMI cases, 4 were found whose initial complication did not occur until day 6, 7, or 8, and of these, 3 died. However, we did not see the onset of complications after

the 8th day; so the hypothesis can be re-stated exactly as above, but changing “within 108 hours” to read “within 8 days” for those with a previous admission for an AMI. In the small probable-recurrent MI group, initial complications were not seen after the 5th day.

TABLE 4.—Median lengths of stay of 455 definite acute myocardial infarction\* cases by history of prior infarction, occurrence of complications, hospital, and level of care. Honolulu, 1974-1978.

HISTORY OF PRIOR INFARCTION	COMPLICATIONS APPEARED	MEDIAN LENGTH OF STAY			
		HOSPITAL	CCU**	INTER. (MONIT.)	TOTAL
No (359 cases)	No	Kaiser	4.8 days	1.7 days	12.4 days
		Straub	3.3	4.0	14.0
		K-Q***	3.0	12.4	17.7
	Yes	Kaiser	6.0	1.4	14.8
		Straub	4.6	5.4	15.9
		K-Q***	5.1	13.4	20.5
Yes (96 cases)	No	Kaiser	4.5	1.5	11.4
		Straub	3.8	3.7	15.0
		K-Q	(too few)		
	Yes	Kaiser	5.5	0.6	11.5
		Straub	4.7	4.7	15.0
		K-Q	(too few)		

\*Limited to those cases meeting strict diagnostic criteria (see text).

\*\*It was not always possible to tell from the record the exact time of changing from CCU to intermediate monitoring status, so there may be some error in the apportioning of length of monitored stay.

\*\*\*See text for caution about small numbers.

TABLE 5.—Distribution of 177 definite first AMI cases suffering at least one complication by the type of initial complication and by outcome. Honolulu, 1974-1978.

INITIAL COMPLICATION**	DIED IN HOSPITAL	DISCHARGED ALIVE	TOTAL
Ventricular tachycardia	1	50	51
Sinus tachycardia	5	27	32
Atrial arrhythmia	4	27	31
Low blood pressure	4	21	25
Ventricular fibrillation	1	17	18
Conduction defect	0	16	16
Extension of infarct	0	4	4
	15	162	177

\*See text for definitions.

Table 4 shows the median length of stay, by hospital, for the 455 cases meeting our diagnostic criteria. The purpose of this table is to go beyond the Duke study (which looked at potential cost savings in terms of dollars) in an effort to study the patterns of use of the CCU, monitoring at an intermediate level, and the total hospital stay. This table allows one to compare the ways in which AMI cases were being managed in the 3 kinds of hospitals included in this study:

Kaiser (Health plan): New, uncomplicated AMI cases were kept in the CCU about 5 days, with many being transferred thence directly to acute care beds rather than via the intermediate monitoring level. Such patients are being discharged at about 12½ days. A similar pattern is evident for recurrent AMI cases.

Straub (Fee-for-service group): A majority of uncomplicated cases received a total of about 7 days of ECG monitoring, including CCU and intermediate unit, and were hospitalized for a total of about 14 days. Complicated cases were monitored for 9-10 days, with a total hospitalization of about 15 days.

Kuakini-Queen's (General community):\* Only the new AMI cases are shown because of the small numbers. It appears that there may be a pattern at each of these hospitals of a fairly brief CCU stay, but a much longer monitoring period, which appears to be related more to which physician is in charge than to whether the patient had a complication or not, and largely explains the overall longer period of hospitalization at these hospitals.

Table 5 distributes the 177 initial AMI cases who survived the first 5 hospital days, who met strict diagnostic criteria, and who suffered at least one complication. Although ventricular tachycardia was the most frequent initial complication observed in this series, the next 3 (sinus tachycardia, atrial arrhythmia, and low blood pressure) were the initial "premonitory signs" for 13 of the 15 subsequent in-hospital deaths. The

\*The median length of stay data are combined here because of the problems introduced by the small sample size from these hospitals. The CCU-monitoring patterns at these hospitals were similar. Caution must be exercised about generalizing from these small samples.



number of deaths in this series was too small for the case fatality rates to be considered reliable for each type of complication.

### Discussion and Recommendations

This study demonstrates that while one can often generalize biological data from limited samples, there are real hazards in trying to generalize utilization (human behavior) data from one hospital situation to another (not to mention the problem of generalizing from Duke Hospital to the entire United States). These Honolulu data clearly support the basic Duke hypothesis, but indicate that it should be modified for those who have had a previous AMI. The Duke group has recently also concluded that those with a previous AMI occasionally have their initial complication later than day 5.<sup>11</sup>

About half of those people who survive their first 5 days of an AMI do so without having developed any specified complication\* during continuous monitoring, and these patients are highly unlikely to develop complications if sent home as soon thereafter as can be conveniently arranged. Complicated AMI cases should be kept longer, probably following current practice, which seems to be appropriate for them. If one adds the nearly 300 uncomplicated cases reported in the 2 Duke studies<sup>8,9</sup> to the 229 such cases (with definite AMI) reported here, the total is over 500 sequential cases identifiable by the 5th hospital day, who then experienced no subsequent in-hospital complication or death. The "exact probability" of a cardiac complication or death during the 2nd week of such an AMI patient is so low that it approximates the 1-week risk of sudden death in the general population.

The Duke prospective study employed the use of Home Care for the first 3 post-hospital weeks to monitor the progress of "early discharge" patients. The value of this practice should be assessed.

The adjustments that might be made to current practice vary considerably according to the

hospital. All are in a position to explore the practical implications of this study.

If any local hospital, group of hospitals, or medical group would wish to evaluate earlier discharge of uncomplicated AMI patients on a prospective basis, our 229 uncomplicated cases meeting strict diagnostic criteria could serve as a pool to provide a control ("long hospitalization") group for case-by-case matching with an experimental ("early discharge") group. The abstracts of these cases will be saved for that purpose. Since neither case-by-case matching nor randomization was done in the Duke prospective study, some uncontrolled confounding factors may have affected the results.<sup>9</sup>

This study is an example of a type of activity that the Professional Standards Review Organization might perform or sponsor in a community, rather than relying so heavily on regional utilization norms, which tend, in non-surgical cases, to ignore the detail that makes for clinical reality.

### Acknowledgment

Gratitude is expressed to the Hawaii Medical Service Association, which paid the wages of 2 part-time record abstractors during the summer of 1978. Sincere appreciation is expressed for the careful, accurate, and diligent work done by those abstractors—David Hudson and Brian Worth. Their work was made possible and pleasant by the assistance and encouragement offered by the medical record staffs of the 4 hospitals cooperating in this study. Thanks also to Drs. Abraham Kagan and George Rhoads for their advice in planning this study, and to Dr. Blair Bennett for statistical assistance. Mahalo!

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\*CCU directors may wish to modify recording methods to facilitate a quick review on day 5 identifying those patients *not* eligible for early discharge by reason of our list of specified complications. Special attention should be paid to the recording of the pulse rate on the flow sheet since moderate sinus tachycardia, which may otherwise be overlooked, was occasionally the only early premonitory sign of an impending fatality.

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# Rx for Malpractice—Informed Consent

H. WILLIAM GOEBERT, JR., M.D., *Honolulu*

"The doctor who proceeds under the doctor-knows-best theory without securing a deliberate waiver from his patient and without disclosing collateral hazards, substitutes his judgment about the desirability of undergoing a risk for that of the patient. Such substitution is inconsistent with the law's respect for the patient's control over his body."<sup>1</sup>

"Informed consent discussions are not well remembered by patients (in fact, they may even generate complications which would otherwise not have occurred) and it turns out that they do not usually provide any help in protecting a doctor who is sued in a malpractice case."<sup>2</sup>

These two conflicting statements illustrate the schism between the M.D. and the lawyer regarding the doctrine of informed consent. No matter what one's personal feelings are about this subject, there is no question that this is a legal cause of action in malpractice; it is difficult to defend, it has been created by the judicial system, and it is decided by a judge or jury. For this reason, physicians must understand the law's requirements.

## Supreme Court's Decision

The law is an ever-changing thing, and it behooves us to look to the future, as well as to the present and past, to avoid malpractice litigation. The Hawaii law on informed consent has previously been determined by the Hawaii Supreme Court.<sup>3, 4</sup> These cases give the following guidelines:

1) It is the duty of a doctor to inform a patient of the risks of any procedures so that the patient may make an intelligent decision as to whether or not to accept the procedure.

2) The doctor may withhold information if he feels that it would be detrimental to the patient's well-being.

3) Expert medical testimony is required to prove that the doctor did not follow the standard of information given by the medical community.

4) Each case will be decided on its facts.

5) The patient or plaintiff must prove that there was no informed consent.

6) The patient and plaintiff must convince the jury that the procedure would not have been accepted if full information had been given.

There is a growing body of law in a number of states, to wit: expert testimony is not needed to determine the standard of information given to obtain consent, allowing the jury to decide whether the patient was given all the information needed.<sup>5</sup>

## Exceptions to Informed Consent

Certain exceptions to informed consent are allowed by the law. These are emergency,<sup>6</sup> instances where the patient does not want to know or waives disclosure,<sup>7</sup> where the risk of the surgery is presumed known to the patient,<sup>8</sup> and where fully informing the patient would endanger his health. Where there is risk of serious complications and death, and this has been told to the patient, it is thereby assumed that lesser risks do not need to be discussed.

Many patients do not want to know all the facts; in fact, too much information may be frightening and may make a patient decide against having needed procedures. When all risks of angiography were explained to 132 patients, 2 refused angiography, 21 said they would have preferred that information regarding possible complications be withheld, 46 said the information disturbed them, but 107 appreciated receiving the information.<sup>11</sup> This shows that psychological trauma from knowing the complications is not as universal an experience as we might suspect. Many patients welcome a chance to discuss the recommended treatment with their doctor. Even so, most patients remember very little of what was told them prior to surgery.<sup>12</sup> Discussions of informed consent were taped on 20 patients. Of these, 2 patients complained that the interviews were brief and not informative. One said, "All he did was lift up my shirt, put a stethoscope on my heart and that was it," whereas



the recorded portion of that interview was 24 minutes long. Post-operatively (4-6 months), only 10-35 percent of the patients recall the risks or possible complications of the operative procedure.

### The Origin of Informed Consent

The law of informed consent started out as an action in battery, which means any wrongful touching without the expressed or implied consent of another.<sup>13</sup> It mattered not whether there was good faith, sufficient skill, or even that no complication resulted. This was clarified in 1914 by Judge Benjamin N. Cardozo, who said that "every human being of adult years and sound mind has a right to determine what should be done with his own body, and a surgeon who performs an operation without the patient's consent commits an assault for which he is liable for damages."<sup>14</sup> From that beginning, the law has continued to redefine and expand this doctrine to provide more open communication between patient and physician. The courts feel the patient has a right to know the risks of a treatment he will receive, alternate methods of treatment, complications of the treatment, and the complications of accepting an alternate treatment.

What risks must the physician include and what type of form will stand up best in court? There is no definite answer for these basic questions. In fact, they are decided retrospectively case by case.

Certainly a complication occurring once in 5,000 times is not a substantial risk and, therefore, would not require a specific disclosure. On the other hand, if a patient turns up with that complication, the physician will be hard pressed to defend himself on the informed consent doctrine. Does this mean, then, that we must have recorded, witnessed, notarized discussions of every conceivable complication for every procedure we do? Surely this is not wise, nor even possible. In fact, the longer the form, the less likely it is that the patient will have read all the fine print and the sooner a jury will realize that the patient signed a document of which he had little or no understanding. When the patient waives a legal right or releases institutions from liability for negligence, this is usually overturned by the court or by the jury.

No one knows for sure what procedures require an informed consent. Recently, I've noted

that spinal taps require informed consent in many hospitals. Should we also require informed consents for CVP's, IV's, Foley catheterization? Surely these procedures also have risks; in fact, at times a higher complication rate than a spinal tap.

### Verbal Consent is Legal

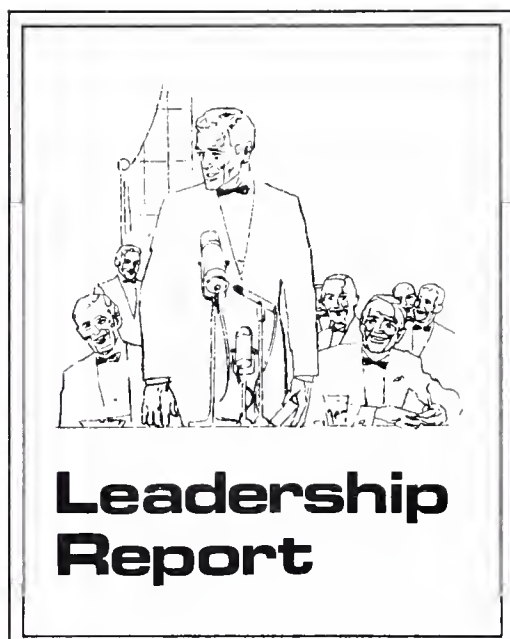
The doctor must consider first which procedures require informed consent. Secondly, will this be verbal or written? A verbal consent is perfectly legal, but some note of it must be made in the patient's record. It should be witnessed by a nurse and made part of the nursing records, as well as part of the physician's records. Notation should be made of the most serious complication discussed with the patient, and that if no complications were discussed, it was done so at the patient's request.

If the consent is written, the procedure should be recorded, the physician doing the procedure should be named, and the patient should be given an opportunity to check whether he wishes to be informed of the risks and complications or does not wish to be informed. The patient should check and sign this section. Following this, a note should be made of the most serious complications discussed, stating that the patient was given an opportunity to ask any questions and that, at the end, no further questions remained. The patient should then sign. Next, he should decide whether he wishes alternatives discussed or not discussed. He should check one or the other and sign. If he wishes alternatives they should be listed; and again he should be given an opportunity to ask questions and then should sign, saying that he has no further questions. He should then be told that no guarantee is being made and that he may withdraw his consent at any time before the procedure is carried out. His signature should be witnessed by the doctor and a third party.

For those patients incompetent to sign—minors or the mentally incompetent—another person should sign and take the responsibility for the patient. If this is done, a note should be made as to why the patient is not signing and the relationship of the patient and the signer. This type of form should improve doctor-patient relationships, lessen the chances of successful suits for lack of informed consent, and minimize our exposure to this form of malpractice.

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JON WON

## HMA COUNCIL BRIEFS

**The Secretary reported** that, as of March 31, 1979, HMA had 925 members, 25 less than the same time a year ago. Only Maui County exceeded its membership of over a year ago. Many physicians on the delinquent list are very active in county and state association activities and programs. Your leadership urges you to please take the time, to not only renew your membership, but also to let us know what committees, activities, or programs you would like to become involved in.

**Cancer agenda item** took up some 3 hours—Dr. Tom Hall, Director of the Cancer Control Program, presented two requests—one, that HMA have an official representative on the CCP Council; the other that HMA subcontract with CCP for certain informational, educational, and technical kinds of programs to be accomplished by HMA on behalf of the CCP. The Council, by a 9-6 vote, approved the first request and referred the second request back to the HMA Cancer Committee for a more detailed look at implementation of the suggested activities and to provide recommendations to Council.

**HMA Cancer Commission** asked the Council to reconsider its position regarding moving HMA's Tumor Registry to the new Cancer Research Center building. After much discussion, the HMA Council, without a dissenting vote, voted to reiterate its present position of keeping the Hawaii Tumor Registry at its present site, 320 Ward Avenue.

**Drs. Douglas Bell, II, HMA President-elect, and Don Char, Chairman of the HMA Community Health Care Committee**, drafted a most noteworthy and excellent testimony regarding the draft of the State Health Plan and presented such testimony at a recent meeting of the Statewide Health Coordinating Council (SHCC). The testimony was very well received, and our information is that the suggestions proposed by HMA have been adopted almost in their entirety

with only minor modifications. A job well done—and can only serve as an example of meaningful physician input.

**School Health Committee** recommended that, at DOH request, HMA send out to all physicians, appropriate information regarding health care in schools, especially procedures for administration of medication to students at school. After much discussion, Council approved sending this information to HMA members.

**HMA legal counsel**, Tom Rice, reported he had reviewed a request by an attorney representing a clinical psychologist to have the HMA join as a friend in suing the State regarding the constitutionality of the investigatory powers of the State's new fraud and abuse unit for Medicaid. While the HMA legal counsel has much sympathy for the intent of the suit, it was felt that such a case should be entered when a physician runs into the same or similar set of circumstances.

**Council discussed the work** of the Fee Survey Committee and felt that the use of the RVS as an updated procedural Terminology Manual is highly meritorious. Suggested that the Fee Survey Committee include such publication costs in its next annual report for consideration for inclusion in next year's budget.

**It was reported to Council** that Argonaut Insurance Company, the only company now writing new professional liability insurance policies in Hawaii, is cautiously looking at the past 2 or 3 years' experience as highly encouraging so much so that Argonaut is looking at a participating policy for professional liability insurance for Hawaii physicians, similar to programs with other medical associations. Dividends under this kind of policy could be in the form of cash, or rate reductions, or both. More as it develops.

**HMA has submitted**, on behalf of the DOH, a grant proposal to the Center for Disease Control, Atlanta, Georgia, to establish a Community Diabetes Control Demonstration Program in Hawaii, beginning with an assessment and planning phase. Should this proposal be successful, DOH will subcontract the project to HMA. Grant awards are highly competitive and only a few can be funded. We wait and see.

**HMA Auxiliary** has been busy with many good kinds of activities and programs in our community, including excellent support of HMA and physician activities. Such activities and programs have used up most of the Auxiliary savings. The Auxiliary, which is allocated so much money per HMA member per year, has had a \$1 per member increase in the last ten years. The HMA Council approved Auxiliary request for additional \$2 per member per year allotment.

## AMA HIGHLIGHTS

**The AMA was dismissed as a defendant** in a lawsuit brought by Common Cause against the



Federal Election Commission. A U.S. District Judge in Washington, D.C., granted the AMA's motion for dismissal, stating that the AMA is an improper party to the suit. The AMA motion was supported by the FEC.

Common Cause filed the suit to force the FEC to act on a complaint charging the American Medical Political Action Committee and state PACs with excessive campaign contributions.

**HEW released an Annual Report** on the nation's health last week, and Secretary Joseph Califano had to admit that Americans "are among the healthiest people in the world." The report, which covers 1976, was compiled by the National Center for Health Statistics and the National Center for Health Services Research. It shows that:

- The death rate for coronary heart disease fell nearly 28% between 1968 and 1976.
- Life expectancy for a person born in 1976 is 72.8 years, compared to 72.5 a year earlier.
- Infant mortality in 1976 was 15.2 per 1,000 live births, compared to 16.1 a year earlier.
- The cancer death rate for people under age 45 dropped from 21.8 per 100,000 in 1950 to 14.7 in 1976.

These were all record achievements in 1976. Later figures are even better. National Center for Health Statistics estimates for 1977 show infant mortality at 14 per 1,000 live births and life expectancy at 73.2 years. Of the 13 leading causes of death, eight had lower rates in 1977. Death rates increased for five, including cancer (though lower for people under 45) and septicemia—and accidents, suicide and homicide.

**The AMA will seek Amendments** to two NHI Bills now before Congress and will support these bills if amendment is achieved, the Board of Trustees unanimously voted last weekend.

- The two bills are catastrophic coverage proposals introduced recently by Sen. Russell B. Long—S 760—and Sen. Robert Dole—S 748.
- The amendments will be based on principles contained in House of Delegates Resolution 62, adopted at the 1978 Interim Meeting, and recommendations of the Council on Medical Service and the Council on Legislation.

Lacking substantive amendments, both bills would be opposed by the AMA. In testimony last week before the Senate Finance Committee, the AMA opposed two earlier national health insurance proposals introduced by Long (S 350 and S 351), but asked that the record be kept open for AMA comments on Long's S 760 and Dole's S 748. Long (D-La.) is chairman of the committee and Dole (R-Kan.) is ranking minority member.

**The AMA urged HEW** to withdraw its proposed list of Medicaid laboratory tests to be reimbursed on a "lowest charge level." The Association pointed out that laboratory services, unlike

medical supplies and equipment, cannot be quantitatively standardized and that this lack of standardization renders the proposed list inapplicable to the lowest charge level criteria under the law.

The AMA stressed that the least expensive procedures may be the least sensitive and the least reliable. It said Medicaid recipients should not have health care standards different from those of the rest of the population. The list allegedly uses identifying codes from the 1964 California Relative Value Studies but, the AMA said, "the tests as numbered and listed do not correspond to the 1964 CRVS nor to any other we are aware of."

**The FTC has received** more than 100 complaints of violations of the federal regulation requiring ophthalmologists and optometrists to give patients a copy of their eyeglass prescription. The regulation went into effect last July 13. Most of the complaints have come from patients and a few from opticians, a Federal Trade Commission attorney said.

### KUDOS

**L.Q. Pang, M.D.**, one of two graduates of Tulane School of Medicine to be honored by the medical center with a new award for distinguished activities as alumni. He received the center's first "Alumnus Extraordinaire" award which honors graduates of the medical school or school of public health and tropical medicine who have made substantial contributions to medicine, public health, and the school!

**K.C. Chock, M.D., and H.Q. Pang, M.D.**, recently honored by Abbot Laboratories with presentations to each of an engraved Golden Hour Clock commemorating the occasion of 50 years of outstanding service and dedication to medicine. This accomplishment by each of these physicians is significant, and the HMA/HCMS leadership commends Dr. Chock and Dr. Pang for this honor, and Abbot Laboratories for the recognition offered to physicians in reaching this important milestone!

### HCMS NOTES

**Beverly T. Mead, M.D.**, psychiatrist, marriage counselor, teacher, and speaker extraordinaire, was the featured program at the HCMS membership meeting on April 9, 1979, at the Kahala Hilton. Dr. Mead spoke to over 100 physicians and their spouses on "How to be Happy Tho' Married!" The dinner meal was a delight, and Dr. Mead provided a most enlightening and entertaining evening for all.

**The medical community was** certainly shocked and saddened by the untimely death on April 4, 1979, of Dr. Felix J. Lafferty, president-elect of the HCMS. It is very difficult to express words about Dr. Lafferty's death but there are so, so many kind ones that can be said. Felix was most active in medical affairs and in life itself. We

wish to express our heartfelt sorrow to his family, and can only say that a true friend of medicine and humanity has been lost.

**Peter Singleton, M.D.**, Chief, Rheumatology, Letterman General Hospital, San Francisco, will be the featured speaker at the next HCMS General Membership Meeting, May 29, 1979, at the Mabel Smyth Auditorium. A light supper will be provided at 0:00 p.m., with Dr. Singleton's presentation, "Anti-Inflammatory Steroidal Therapy: Fact or Fiction," to follow at 0:00 o'clock, and a wine-tasting experience to follow Dr. Singleton's presentation. Much of this meeting is made possible through the cooperation and generosity of McNeill Laboratories. Please plan to be there.

### HMA NOTES

**The symposium on sexual problems**, held Sunday, April 8, 1979, at the Ilikai Hotel, sponsored by the HMA, Nurses Association, and the Pharmacy Association, was a sell-out! Over 1,000 registrants, but due to space limitations at the hotel, some 200 registrants, had to be turned down. As it was, some 680 physicians, nurses, and pharmacists attended and heard Beverly Mead, M.D., Joseph Trainer, M.D., and Jack Anon, Ph.D., and Craig Robinson, Ph.D., present a most fascinating discussion and scenario on a most fascinating topic!



### Could Be Useful

Talk about patient package inserts (PPI) has evolved into a tempestuous polemic, with professional folks who should know better taking sides and even flexing legal muscles. The American College of Physicians' position on PPI's is predicated on a simple verity: a well-informed patient is just more likely to be cooperative, and follow therapeutic advice, than one who is not. The PPI must be designed to complement the instructions

of the physician: it should not be a freestanding document.

It follows that the PPI must be written in simple, uncluttered, comprehensible language. It must be educational, not scary. It should not contain alarming information (ie, emphasis on severe, very unlikely adverse effects, without appropriate, clear-cut, qualifying statements).

Therefore, clinicians must have significant input into the writing of patient package inserts. If the profession were to follow intemperate advice and turn its back on PPI's, these critical documents could go on being written by anonymous "hired pens"—poorly schooled in the subtleties of communication with anxious patients. Under such circumstances, PPI's could be counterproductive, by instilling fear or creating uncertainty, as they not infrequently are today.

If these documents can be written by clinicians who are sensitive to the vagaries of patient needs and reactions, they can serve to greatly enhance "compliance"—or far better, *cooperation*—with the proposed treatment.

ROBERT H. MOSER, M.D.  
Executive Vice President,  
American College of Physicians

### A Novel Concept

We were recently advised by the Physicians Protective Association of Hawaii (PPAH) that



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their members have accumulated over three hundred fifty physician-years without a malpractice suit.

The Association provides legal defense to its members, but its by-laws prevent payments for settlements or judgments. Physician members note that plaintiffs' attorneys have dropped every potential case once they discovered that the physician involved did not have conventional liability insurance.

The group was formed during the 1976 insurance crisis, modeled after common practice in Great Britain, where medical lawsuits are rare. PPAH physicians are not completely "bare," since they are insured for expenses incurred in defending themselves. Members remain liable for any judgments, however, and this awareness may produce a more meticulous practice of defensive medicine.

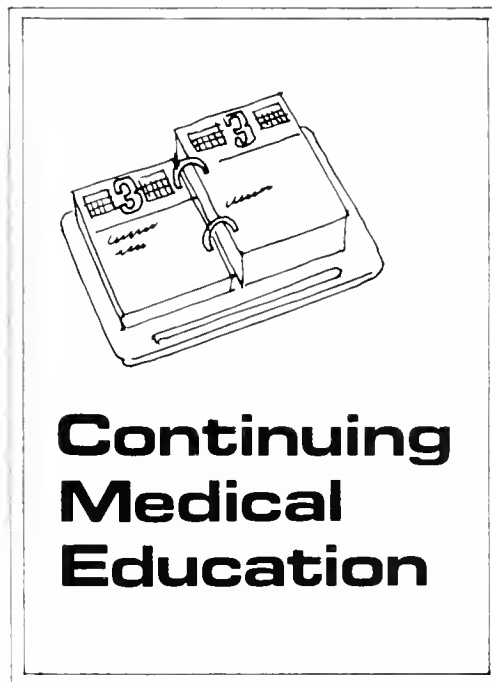
Though it is far too early to draw actuarial conclusions, the hundred twenty-five members have so far shown an impressive score. Whether this results from improved physician selection and practice, or in fact reflects a lack of attorney interest in cases not likely to be easily remunerative, is not yet certain.

But the concept expressed by PPAH founders that "a chief cause of malpractice suits is the mere existence of malpractice insurance," is an intriguing one, the validity of which will be determined in the years ahead. It just may be that,

as the availability of third party medical payments tends to promote elective treatment, so may liability insurance promote elective lawsuits.

The notion that liability "protection" increases liability lawsuits is a novel one. Even if this is only half true, the corollary is fascinating; it will be interesting to watch the PPAH score over the coming years.

J.M.C.



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.
9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.



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**Hickam Clinic**

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

**Hilo Hospital**

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

**Kaiser Hospital**

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
  2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
  3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
  4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
  5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

**Kapiolani-Children's Medical Center**

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

**Kuakini Medical Center**

1. Visiting Professor Program
  2. Guest Speaker
  3. G. I. Conference, 3rd Tuesday, 8:00-9:00 a.m.
  4. Nephrology Conference, 4th Wednesday, 8:00-9:00 a.m.
  5. Oncology Conference, every Thursday, 7:30-8:30 a.m.
  6. Surgical Conference, 1st, 2nd and 3rd Fridays, 1:00-2:00 p.m.
  7. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 1:00-2:00 p.m.
  8. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, 1:00-2:00 p.m.
  9. Ophthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
- (Contact CME Dept.-Kuakini for further information)

**Maui Memorial Hospital**

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd.—Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., 3rd Mon., 7-8:00 a.m.
4. Family Practice Section—3rd Wed. 7-8:00 a.m.
5. Diagnostic Radiology—4th Tues., 12-1:00 p.m.

**The Queen's Medical Center**

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium  
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium  
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium  
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

**St. Francis Hospital**

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Hematology Conf., 3rd Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
7. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

**Straub Clinic & Hospital**

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

**Wahiawa General Hospital**

1. Noon Seminars, Every Tuesday

**Wilcox Hospital (Lihue)**

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817



At: Local Hospitals, Honolulu  
 Type: I, 1 hr./day, 1 day/mo. from 12 mos.  
 Fee: None Methods: AV, O, Pan  
 Dates: All yr., 12 hrs. instruction

## SPECIAL EVENTS

- Apr. Orthopedic Review, USC Sch of Med, Div of  
 May 18, Postgrad., 2025 Zonal Ave., LA, CA 90033.  
 1979 Held at Mauna Kea Beach Htl, Kamuela. 5  
 days, 30 hrs.
- June 3- Diving Med. U of H Schl of Med. 1960 E-W  
 9, 1979 Rd., Honolulu 96822. Held at King Kameha-  
 meha, Kailua-Kona, HI. 6 days. Cat. 1—25  
 hrs. Contact: CCECS, UH, 2530 Dole St., Ho-  
 nolulu 96822.
- June 9- Radiology, USC Sch of Med., Div. of  
 16, 1979 Postgrad., 2025 Zonal Ave., LA, CA 90033.  
 Held at Mauna Kea Htl, Kamuela. 5 days, 30  
 hrs.
- June 14- "Patient Learning Through Effective Use  
 20, 1979 of Media"—1979 Phys. Seminar on Patient  
 Ed.-20 hrs. Cat. 1 CME. Co-sponsor HMA. To  
 be held at the Kuilima Hyatt Resort Htl. Con-  
 tact: Media Institute, S 607 1833 Kalakaua  
 Ave., Hono. 96815 or (808) 955-5908.
- June 18- Comparative Psychotherapies, USC Sch of  
 22, 1979 Med., Div. of Postgrad., 2025 Zonal Ave., LA,  
 CA 90033. Held at Royal Lahaina Htl, Maui. 5  
 days, 30 hrs.
- June 23- Manipulative Med. USC Sch of Med., Div. of  
 30, 1979 Postgrad., 2025 Zonal Ave., LA, CA 90033.  
 Held at Sheraton-Waikiki, Honolulu. 5 days,  
 30 hrs.
- Aug. 4- Ophthalmology, USC Sch of Med., Div. of  
 11, 1979 Postgrad., 2025 Zonal Ave., LA, CA 90033.  
 Held at Mauna Kea Beach Htl, Kamuela. 5  
 days, 30 hrs.
- Aug. 8- 22nd Annual Postgrad Refresher Course,  
 22, 1979 USC Sch of Med., Div. of Postgrad., 2025  
 Zonal Ave., LA, CA 90033. Cosponsor: U of  
 HI. Held: Honolulu, Maui & Kona. 39 hrs.
- Sept. 9- Practical Management of Anesthetic  
 17, 1979 Problems, USC Sch of Med., 2025 Zonal Ave.,  
 LA, CA 90033. Held at Mauna Kea Beach Htl,  
 Kamuela. 5 days, 31¼ hrs.
- Oct. 9- 123rd Annual Convention-HMA/AMA Re-  
 12, 1979 gional Mtg. Ilikai Htl. Honolulu. 5 days.  
 Contact: HMA Office (808) 536-7702.

## OUT OF STATE

For information on any out-of-state programs or courses,  
 refer to August 15, 1977 Supplement to JAMA or call the  
 HMA Office.



## Annual Review of Neuroscience, Volume 2, 1979

*Edited by W. Maxwell Cowan, Zack W. Hall, Eric R. Kandel, Annual Reviews, Inc., Palo Alto, California, 555 pages.*

*Annual Review of Neuroscience, Volume 2, 1979* provides an informative and exciting companion to Volume 1 (1978). In Volume 2 the reader discovers chapters devoted to the visual system, vestibular mechanisms, biochemistry and modulatory actions of neurotransmitters, axonal transport, central catecholamine neuron systems, steroid action on the brain, opiate receptors, the biology of affective disorders, development of behavior in human infants, ion channels in development, sodium channels in myelinated axons and slow viral infections. All of these chapters are excellent reviews with key references, figures and tables.

An added treat for the reader is the introductory chapter by Seymour S. Kety entitled *The Metamorphosis of a Psychobiologist*. Kety recognizes the pertinence of the neurosciences, in conjunction with psychological and social sciences, to further progress in the understanding, treatment and prevention of mental illness.

It has been a pleasure to review Volumes 1 and 2 of *Annual Review of Neurosciences*. I would recommend both volumes to those in the neurosciences.

KENNETH K. NAKANO, M.D.



## BLEMISHES?

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**Friday, February 2, 1979  
5:30 p.m.**

**HMA CONFERENCE ROOM  
PRESENT:**

Drs. Goto, Bell, Winn, Hindle, Hanlon, Chang, Azman, Miyashiro, Miles, Bruce, Fong, Cahill, McNamee, Roth, Lafferty, Clingan, Fu, Wigle, Magoun, Mills, Kuboyama, Char, Dang, Sia, Catts, Simmons, McEwan, and Mr. V. Thomas Rice. HMA Staff present were: Mr. Won, Mr. Saranchock, Mr. Leineweber, Mr. Ajifu, Mr. Ontai, Mrs. Chang, Mrs. Kendro, Mrs. Wong, and Mrs. Young.

**CALL TO ORDER:**

The meeting was called to order by President Goto at 5:50 p.m.

**TREASURER:**

The December 1978 financial statement was reviewed in detail and approved subject to audit.

**REPORTS OF THE COMMITTEES  
AND COMMISSION:**

*A. Membership:* With regard to membership recruitment, Mrs. Ceci Young reported that a special mailing to all non-member physicians and housestaff in the State was recently completed, and it is expected that a mailing to medical students will be done in the near future. In addition, the HCMS Recruitment Committee has made plans to conduct follow-up on an individual basis.

*B. Cancer Commission:* Dr. Drake Will reported that he will soon convene a meeting of the Cancer Commission. He hopes to have the Commission formulate recommendations on ways in which the HMA can utilize the data generated by the Hawaii Tumor Registry. The Council reviewed the nominations to the Commission which were submitted by the Department of Health, Hawaii Division of the American Cancer Society, and University of Hawaii.

**ACTION:**

**It was moved, seconded, and passed that the following physicians be appointed to the Cancer Commission to represent their respective organizations:**

**Department of Health:**

**Dr. John Chalmers (1979) to replace**

**Dr. Kirsten Vennesland**

**Dr. Verne Waite (1981)**

**American Cancer Society:  
Dr. Reuben Guerrero (1981)**

**ACTION:**

**It was moved, seconded, and passed that Dr. Thomas Hall (nominee of University of Hawaii) be invited to participate in the activities of the Cancer Commission and that he be formally elected when he becomes a member.**

*C. Medical Education Commission:* Dr. Nadine Bruce reported that members are being encouraged to apply for a PEC award, as an interim measure for those who have not obtained a PRA award. In the near future, Hilo Hospital will be resurveyed; and Kona Hospital will be surveyed for the first time. It was also reported that provisional I-year accreditation was recently granted to the Federation of Emergency Medicine, Inc. The CME Committee is now receiving requests for accreditation from smaller groups, as well as commercial organizations.

*D. Internal Affairs Commission:* Dr. Neal Winn reported that the HMA's 123rd Annual Meeting will be held on October 8-12, 1979, at the Ilikai Hotel. The House of Delegates will meet on Monday (Oct. 8) and Wednesday (Oct. 10). The golf tournament has been scheduled for Thursday (Oct. 11) at Leilehua Golf Course, with the Sportsmen's Night Party to follow at Kanraku Tea House. The Arrangements Committee has been in communication with pharmaceutical representatives and as a result, has decided that exhibits will be held on three days instead of five, Monday through Wednesday (Oct. 8-10).

*E. Public Affairs Commission:* Dr. Philip McNamee requested guidance from the Council on whether it would be appropriate to sponsor another Health Fair (similar to that held in 1968) in conjunction with the 125th Anniversary of HMA in 1981.

**ACTION:**

**It was moved, seconded, and passed that a Health Fair be sponsored in 1981 in conjunction with HMA's 125th Anniversary; that an ad hoc steering committee be appointed to plan and coordinate this event; and that funds be channeled through the Community Research Bureau.**

*F. Health Service and Care Commission:* Dr. Donald Char recommended that the HMA submit nominations to the Governor for possible appointments to the Statewide Health Coordinating Council and Subarea Councils, since many terms have expired.

1. Certificate of Need: The Council reviewed recent correspondence with SHPDA regarding proposed amendments to the Certificate of Need law. The HMA has recommended to SHPDA that HRS 323D-41(6) pertaining to the definition of an "organized ambulatory health care facility" be amended. HMA has expressed its willingness to work with SHPDA to establish further criteria in the rule-making process. It is proposed that such criteria will make it possible to differentiate between the private practice of medicine and "organized ambulatory health care facilities." Informal word was received that an Administration bill will be introduced as suggested by the HMA.

2. Grant Application: Dr. Char reported that HMA was asked by SHPDA to comment on the UH School of Nursing's grant application for the establishment of a (graduate) nurse practitioner program. The Council reviewed HMA's response of 12/29/78 which suggested that action on the grant proposal be deferred until such time that the SHPDA Manpower



Task Force has addressed the present and future needs of the State for such health care professionals.

3. *Wellness Celebration:* Dr. David McEwan reported that the HMA has been asked to participate in and contribute funds to the Wellness Celebration (which is being spearheaded by the DOH and a group of concerned citizens), to be held in conjunction with the Governor's proclamation of Wellness Week. The Council was informed that the celebration is an integral part of the Wellness Plan, recently adopted by the SHCC Plan Development Committee and is an effort to increase community awareness and access to various avenues of the "wellness" concept (such as nutrition, physical fitness, meditation, etc.). Dr. McEwan recommended that the HMA participate and contribute financially.

**ACTION:**

**It was moved, seconded, and passed that the HMA contribute \$500 to the Wellness Celebration; that the HMA actively participate in the celebration by sponsoring a presentation; and that an appropriate committee be designated for follow-up of the above. There were two opposing votes.**

Dr. Char reported that four other task force plans on high-risk perinatal services, end-stage renal disease, computed tomography, and radiation therapy have been approved by the SHCC Plan Development Committee; and it is expected that SHCC will accept the plans for inclusion in the State Health Plan.

4. *Meeting with Representative Herbert Segawa:* Dr. Marion Hanlon reported that a meeting was held with Representative Segawa to discuss the role of HMA's Health Care Cost Committee and physicians' cost containment efforts. The Health Care Cost Committee is planning to publish a brochure to encourage cost awareness for distribution to all physicians in the State, and will also develop a simple program for discussion with hospital medical staffs. The Council agreed that the minutes of the Health Care Cost Committee be forwarded to Representative Segawa.

5. *Voluntary Cost Containment Committee:* Dr. George Mills noted that the Voluntary Effort is waiting for its fourth quarter report (1978), but it appears that the Voluntary Effort will exceed its goal of 2%.

6. *9% Solution:* The Council reviewed a report from Dr. Felix Lafferty and Mrs. Becky Kendro on the proceedings of the recent 9% Solution meeting at Princeville. Dr. Lafferty reported that a "super board" was created as a result of the meeting, which consists of two members from each hospital's board of trustees.

*G. Legislative Commission:* A summary on legislative activity was presented by Dr. E. Lee Simmons. It was reported that approximately 50 physicians and guests attended the HMA's Legislative Workshop held on January 10 and 11. The workshop was conducted by Senator Pat Saiki, who focused her informative presentations on the details of the legislative process, lobbying techniques, etc.

Dr. Simmons also reported that a subcommittee to review the status of the medical malpractice law will be chaired by Dr. Philip Hellreich. The subcommittee will also consider introduction of related legislation (such as periodic payments, informed consent as sole cause of action, etc.). Meetings will be held with the

Insurance Commissioner and Argonaut Insurance Company.

Dr. Simmons reported that the Legislative Committee has met with various people from the community to discuss what were felt to be issues facing the HMA during the current legislative session. Issues expected to arise are: use of diagnostic drugs by optometrists, generic drugs, Medicaid, EMS, manpower of allied health professions, health care costs, abortion, minors' consent to family planning services, C.O.N. (organized health care facility), and worker's compensation. It was reported that Kazuhisa Abe has agreed to serve as HMA's legislative counsel.

*II. Emergency Medical Services:* Dr. William Dang reported that the EMS program has combined its EMT course and MICT-A course into a 315-hour course and has just finished the first classes, with the second classes to start March 5. He also noted that the contract with the DOH for emergency medical services is pending. Funds will be forthcoming to the HMA when the contract is finalized.

*I. Rubella Update:* Dr. Denis Fu reported that the Communicable Disease Committee met with DOH representatives to affirm the HMA's stand against mandatory premarital screening and to formulate a plan for voluntary rubella screening and immunization. Mr. Yuen felt that the consent for rubella testing could be included in the VDRL form.

The Council also reviewed Senate Resolution 41 calling for mandatory premarital rubella screening and agreed that it should be opposed.

*J. Medicaid:* Dr. Roy Kuboyama presented a summary report of a recent meeting with Mr. Andrew Chang, Director of the DSSH, at which time DSSH representatives discussed their ideas on possible ways to control costs of the Medicaid program. The Council also reviewed a 1/31/79 article from the Star-Bulletin containing statements made by Mr. Chang relative to the Medicaid program. There were some misrepresentations in the article. The Council recommended that corrective measures be taken by HMA to clarify the misrepresentations. The Council agreed that Dr. Kuboyama should prepare a response to the Star-Bulletin.

HMA's testimony on the DSSH's proposed amendments to Rule 8, Section 3482.05 (Rules and Regulations governing the Medical Assistance Program—Medicaid) was circulated to the Council. DSSH's proposed amendments would permit the Department to establish a Formulary Committee that would establish a formulary of prescription preparations to be covered under the Medicaid program. The testimony outlines concerns of the Substance Abuse Committee and was presented by Dr. J. K. Sims at a public hearing on January 30, 1979.

*K. Bureau of Research and Planning:* The Council appointed the following physicians to the Bureau of Research and Planning:

Herbert Chinn (1981)  
William Hindle (1981)  
Winfred Lee (1981)  
Sakae Uehara (1981)

*L. Computer Report:* Mr. Jon Won presented a report to the Council on possible computerization of some of HMA's operations. It was pointed out that this exploration is the result of tremendous growth in HMA activities and future demands anticipated, in

areas such as CME requirements for licensure, accounting, membership recruitment and support, record of HMA positions, etc. Mr. Won cautioned the Council that conversion to a computer is a complex and costly undertaking (\$75,000 to \$100,000), which would be accompanied by its own set of problems. Since such a project would require a large commitment of resources, Mr. Won requested direction from the Council regarding further pursuit in this area.

**ACTION:**

**It was moved, seconded, and passed that Mr. Won investigate purchase, lease, or other options for computers.**

The Council recommended that the Executive Committee or appropriate leadership be involved in the determination of HMA's future computer needs.

*M. Building:* Mr. Andrew Saranchock provided the Council with an update on HMA building leases. It was reported the negotiations with Locations, Inc. will be finalized shortly. Ann Jefferies has signed a lease for \$1.10 per square foot for another 5-year term. Most recently, informal notification was received that National Escrow may desire to move from the building. However, staff space requirements may need to be evaluated prior to a final determination on how the space should be leased. Mr. Saranchock noted that the Hospital Association has indicated an interest for more space.

With regard to reroofing of the building, Mr. Saranchock reported that a portion of the payment is being withheld until problems with damaged autos and smudges on the building are settled. A percentage is also being withheld until a notice of completion is filed.



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It was also reported that the Building Committee has been considering the possibility of a 10-year fixed lease period on the current ground lease. In order to pursue the possibility of extending the ground lease period, HMA must obtain clear title to the building. It was noted that the committee is presently not pursuing the matter of refinancing because of current high interest rates.

**REPORTS OF COUNTY MEDICAL SOCIETIES:**

*A. Maui:* Dr. Ben Azman, President, reported that Maui's thrust will be on membership recruitment. The Society plans to invite non-member physicians to meetings periodically; the first of such meetings was held on January 16 and Dr. Donovan Ward, Past President of HMA, was the guest.

*B. Hawaii:* Hawaii County's President, Dr. A. Scott Miles, reported that Hawaii County plans to hold four major meetings per year. Emphasis will be on CME and increasing membership.

*C. Kauai:* Dr. Yonemichi Miyashiro, President, reported that Kauai County will hold its next meeting in March. The Society plans to conduct a membership drive on a one-to-one basis.

*D. Honolulu:* Dr. Felix Lafferty, President-elect, reported that Honolulu County has just established an Impaired Physician Committee in an effort to help fellow physicians with problems such as mental illness, substance abuse, etc.


**NEW BUSINESS:**

*A. Legal Counsel:* The Council agreed to re-explore the HMA's position on physician dispensing of drugs and use of radiology technicians. It was further decided that Mr. V. Thomas Rice should assist an HMA member who is involved in questions relating to these items.

*B. ICOSH (Hawaii Interagency Council on Smoking and Health):* The Council voted to support ICOSH with a contribution of \$50.

**ADJOURNMENT:**

The meeting adjourned at 10:40 p.m.



**Hawaii  
Academy of  
Family  
Physicians'  
Newsletter**

J. I. FREDERICK REPPUN, M.D.

**New Members—**Manuel L. Bulanon MD is a new Active member in Wahiawa. A new Resident Affiliate is Michael Noce MD. Another new Active member is



Wahiawa resident **Maynard R. Olsen MD.** We welcome these three to our growing ranks, the latter by transfer from New Jersey.

**News of Members**—We note that **Glenn Stahl** is a director of the Kaneohe Business Group; ie, he's becoming active in extra-professional community affairs. **George Monlux** has formally transferred to the Alaska AFP. We beg leave of **David Livingston** in publishing herewith his incredible record of CME: The computer announces he has 246.5 "P" and 207 "E" for a grand total of 453.5 hours for the period 1977 and 1978! **Wilmot Boone**, a 28-year member of this chapter, is now practicing on Wake Island but still maintains his home in Kona on Hawaii. **Ron Hattis** on Kauai has written a long letter expressing frustration over the confusion between AMA Category 1 and AAFP "P". He also is battling and is baffled by the AAFP computer. We're all in this together, Ron, so keep battling both! **Helen Percy** at Lahaina can't figure out how to xerox her Permaplaque upon the HMA Education Certificate. Helen, HMA accepted my being in good standing in AAFP and told me to forget about their certificate; so, no worry, brah! A letter from **Vernon** and **Martha Boido** in Fresno, California brings us up to date on these "transfers out."

**24 March Dinner Meeting**—up at **Liljestrands** eyrie on Tantalus was a considerable success with an attendance of 70, including 7 Student members. **Mona Bomgaars**, among other very interesting things about Family Practice in the Third World, related how she was called upon to perform 25 C-sections in one month's time in India, 5 of them being for ruptured uteri; that malnutrition with weakness and anemia concomittantly account for most of the medical problems in that country.

**ABFP Diplomates Roster**—includes the following from this chapter: **Azman, Cahill, Dilcher, Exton, Glover, Hase, Jasinski, Fred Lam, Livingston, Miller, John Newman, Percy, Sowers, Swanson, Todd, Pat Walsh, Wigle; Bade, Bell, Bomgaars, Farrell, Harrison, Hattis, Langworthy, Lincoln Luke, Schroeder, Stahl, Tokeshi; N. Baysa, Dietrich, Dodge, Freeman, Haling, Hartner, Kern, Machigashira, McLaughlin, Don Newman, Padwick, Shlachter, Tesoro, Van Putten, and Wentworth** for a total of 43 who are certified and recertified "specialists" in FP.

**HCMS Board of Governors**—this Chapter is honored that the following non-member general and family practitioners have elected to have our representa-

tive and alternate to the B of G represent them as well: **Akita, Ballard, Tom Chang, Y. P. Chang, Harri Davies, Fessenden, Higashi, Ken Ing, Bill Ito, Joe Kam, Kimura, M. Kuramoto, Leslie Luke, McEwan, Noda, Tien, Tomita, S. Tyau, R. Uyeno, Weinstein, William Wilkinson, and Herb Wong.**

**Future CME**—Don't forget the "Big ONE" in August: USC—UH—TAMC can give you maybe 35 "P"! Anyone interested in going to Oregon 3-6 May at Eugene; the Oregon Chapter will hold its Annual Scientific Assembly, good for quite a few hours of "P" credit.



**Addendum**—as this Newsletter goes to press, we note with great sadness the sudden and unexpected demise of **Felix J. Lafferty MD** on 4 April 1979, after a very brief illness.

Felix joined the Academy in October 1961. He soon assumed leadership positions; he served as President of the Chapter. For over ten years past he has been its delegate to A.A.F.P., where he served the national organization on its committees and barely missed being elected one of its directors two years ago.

Felix loved his profession. He was dedicated to the Family Practice of Medicine. Felix loved his fellow man. His patients were his friends, and they are legion. Felix was himself a devoted family man, to his wife Jewel and their sons. Jewel was as one with Felix in his devotion to his practice and his patients. Felix was a model of the ethical and the dedicated doctor, firm in the conviction of his honest principles, willing to sit in judgement of his colleagues because he felt he was helping to educate and elevate them for the good of the profession and not to penalize; he was sincerely compassionate and fair, therefore greatly respected. Felix was a strong man.

This Chapter, the A.A.F.P., organized medicine under the banner of the A.M.A., and the profession as a whole has lost a real leader who was still climbing the apogee of his career. To those of us who were his close friends, and especially to his beloved family, Felix' premature death brings grief—and long remembrance.



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**Chung Ta Hsin, M.D.**

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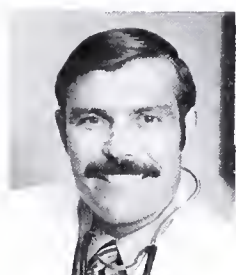
RADIOLOGY



**Myron B. Lezak, M.D.**

1697 Ala Moana Boulevard  
Honolulu, Hawaii 96815

GASTROENTEROLOGY



**James E. Musgrave, M.D.**

1380 Lusitana Street, Suite 814  
Honolulu, Hawaii 96813

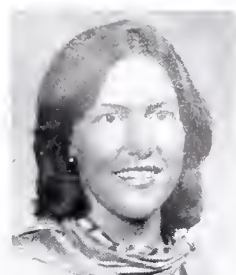
PEDIATRIC NEPHROLOGY



**Praphan Puapongsakorn, M.D.**

45-602 Kam Highway  
Kaneohe, Hawaii 96744

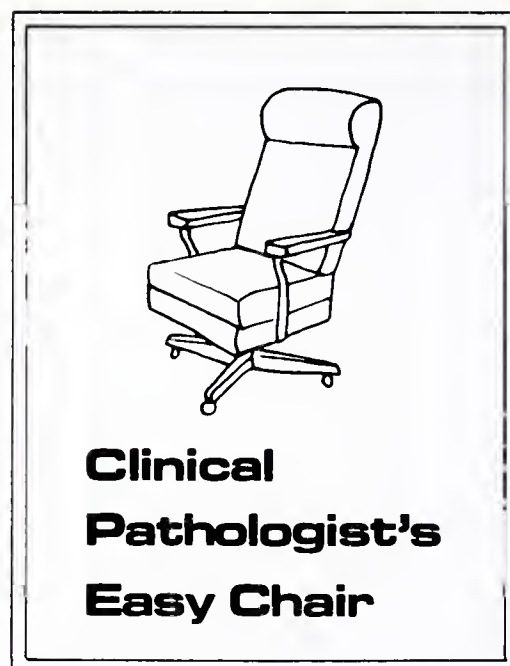
INTERNAL MEDICINE



**Helen L. Sullivan, M.D.**

745 Fort Street  
Honolulu, Hawaii 96813

GENERAL PRACTICE



FRANCIS FUKUNAGA, M.D.

## Therapeutic Drug Monitoring

Numerous factors affect the relationship between dosage and intensity of pharmacologic effect of drugs. Many of these are individual differences. The concentration of drugs reaches an equilibrium in tissues and extracellular fluids and the pharmacologic effect of most drugs tends to be proportional to their concentration in the extracellular fluids.

However, the relation between dosage and plasma concentration is unpredictable with many drugs. The usual dose of a drug may be ineffective in some patients but toxic in others. Experience has shown that plasma drug levels correlate with clinical effect better than drug dosage does. The objective of drug monitoring is to keep drug concentrations at optimal levels to minimize the probability of exacerbation of the disease or toxic reaction to the drug.

Trial and error therapy is at the mercy of a number of unknown factors. Most drugs are taken orally and many factors can alter the amount of drug absorbed by the gastrointestinal tract: solubility of the drug, the type of drug preparation, and the presence of food and other drugs. The type of filler in the tablet may cause differences in absorption and medications: antacids alter drug absorption by coating the absorptive surfaces, or chelate and sequester various drugs. Drug dosage does not have a linear relationship with total plasma concentration. Because of the phenomenon known as saturation kinetics, there is a disproportionate increase of plasma levels after a certain concentration has been reached and a rapid development of toxic effects may ensue following a dose that is not expected to cause such an effect.

Patient non-compliance with a prescribed drug regimen is the most common cause of low blood concentrations and this is especially true if the levels are consistently low. This may be due to failure of the patient or nurse to follow directions properly or the directions may have been inappropriate.

The absorption of oral medication should be assessed. If the problem is malabsorption, parentally administered drugs will give significantly higher levels than an oral dose. Rapid metabolizers will show no significant differences regardless of the route of administration. The drug may be metabolized rapidly



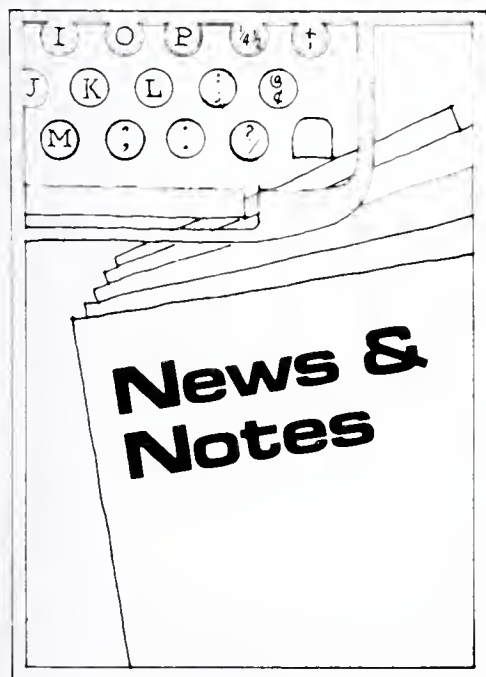
due to some genetic differences: e.g., the more rapid metabolism of INH by some patients. Many drugs have metabolic products that provide varying therapeutic effects and some drugs are inactive until metabolized. An example is procainamide, whose metabolic product N-acetylprocainamide has significant antirhythmic properties.

Drug interaction in plasma can alter its effects. Dilantin is bound by plasma proteins and the free or unbound Dilantin is responsible for its therapeutic effect. Should some other drug that can displace the Dilantin from its binding site be given, such as penicillin, the free portion will increase and cause toxic effects.

The plasma half-life of drugs reflects the elimination characteristics that involve the function of the liver, kidney, and receptor organs. Those bound less by protein have a shorter half-life. Most drugs can be considered eliminated in four to five half-lives. The clinical status of the patient can alter drug utilization. Degradation of some drugs is markedly reduced with liver impairment because of loss of its ability to metabolize the drug. Renal function is also important since the kidney is the major pathway of drug elimination.

#### RECOMMENDATIONS IN DRUG MONITORING:

1. Drug level determination at steady state concentrations to allow adjustment of dosage for individual differences in metabolism and excretion of the drug.
2. Periodic monitoring at random intervals to detect patient non-compliance.
3. During any concomitant illness that may alter physiologic function and thus alter drug utilization patterns, especially renal and hepatic failure.
4. Detect possible drug interactions when more than one drug is taken.



## Life In These Parts

For hundreds of years, beekeepers have maintained that bee venom is a cure for arthritis. The Arthritis Foundation and others in the medical profession take a dim view of this folk lore. When a Charles Mraz was here in February as a consultant to the Hawaii Beekeepers' Association, he related how he had arthritis 45 years ago in both knees and having

heard the story about stings curing arthritis, he put two bees on the affected area until they stung, just to see what would happen. The arthritis disappeared and hasn't returned. Since then, he has treated hundreds of people for no fee. Mraz claims he isn't practicing medicine without a license because "there's no law against getting stung by a bee, you have the right to get stung if you want, and if there were a law I don't think the bees would pay any attention to it." Melvin Levin, chairman of the medical and scientific committee of the Hawaii Chapter of the Arthritis Foundation said his organization considers "bee venom therapy worthless . . . Since arthritis is episodic . . . it waxes and wanes . . . There's a tendency to attribute cure to something they've eaten or taken at the time they have the remission . . ."

## Professional Moves

*Homo sapiens medicus* is stirring and no longer dormant . . . In February, we started to note the increased activity with cardiologist **James Williams** joining the Kaiser Permanente Medical Care Program and eye man **Stephen D. Miller** doing the same. Psychiatrist **David Des Jarlais** joined the Straub Clinic. On Kauai, pediatrician **Lee A. Evslin** joined the Kauai Medical Group and on the Big Island, gastroenterologist **Edwin Montell** joined the Hilo Medical Group . . . **Kirsten Vennesland**, chief of the Tuberculosis Branch of the DOH Communicable Disease Division since 1969, retired.

In March, neurosurgeon **Kazuo Ugajin** and cardiologist **Allan Pribble** joined the Kaiser Program and plastic surgeon **Gunther Hintz** announced the opening of two offices, one at Suite 800, 677 Ala Moana Blvd. and a Kona Office at the Kealakekua Post Office Bldg. Internist **Wayne Lum** opened his office at the Atlas Insurance Building, 1150 So. King Street and internist **Kenneth Lee** took over **Minoru Kimura's** practice at 1833 No. King Street.

## Sportsmen

"No matter what happens to Primo beer, there will still be a Primo Relay and Primo Ultra-Marathon race this year. **Dr. Jack Scaff** says the Honolulu Marathon Assoc. is so grateful for Primo's past help that even if it folds, there'll still be a Primo run . . ." (George Daacon, Feb. 5)

The Honolulu Medical Group has established a department of sports medicine designed to handle sports-related medical problems. The staff will include orthopods **Robert L. Smith**, **Thomas Owens**, **Kent Davenport** and **John Smith**; OB Gyn man **Rick Williams**; cardiologists **Vincent Friedewald** and **John Cogan** as well as FP **David McEwan** who specializes in weight control . . .

## Elected, Honored & Appointed

On the academic front, **George Rhoads** and **William Hammon** were appointed to American Heart Association Council Fellowships . . . **Robert Dailey Irvine** of Hilo was inducted as a Fellow of the American Academy of Orthopaedic Surgeons at its 46th Annual Meeting in San Francisco. ENT man **Lup Quon Pang** was honored by Tulane Medical Center with its new award, "*Alumnus Extraordinaire*" designed to honor graduates who have made substantial contributions to medicine, public health and who have demonstrated unusual support and enthusiasm for the university . . . Associate Dean **John Wellington** was confirmed as Acting Dean of the John Burns School of Medicine during **Terrance Roger's** 18-months' leave of absence . . .

Straub Hospital medical director **George Ewing** was one of the 1979 Riley Allen Award recipients for creative advertising in the Star Bulletin's "Hawaii 20/20" edition . . . **Ron Pion** won the Communications Award at the 1979 Honolulu Sertoma Club ceremony with 13 other winners in specific categories . . . **Col. David Swanson**, director of the family practice residency program at Tripler Hospital, was installed as president of the Hawaii Chapter of the American Academy of Family Physicians . . . **Patricia Dietrich** was elected president-elect; **James Tsuji**, secretary; and **Fred Reppun**,

treasurer. New governing council members elected are **Don Newman**, **Glenn Stahl**, and **Lincoln Luke**. **H. Q. Pang** was honored for his 50 years of active practice as a family physician . . .

**Ronald Hattis** of Waimea was among the top ten in the Hawaii Jaycees 1978 Recognition and Awards Banquet at the Hilton Hawaiian Village. Ron was nominated for his outstanding public service in the field of medicine relating to pesticide use, the statewide rubella immunization program of 1976-77, the foundation of the Kauai Emergency Medical Service Council, his work with the West Kauai Jaycees, etc.

We congratulate the following physicians for being selected as among the top 20 in the health field who had an impact on health care in Hawaii . . . **Scott Brainard** for being the first surgeon to perform open heart surgery in Hawaii in 1958 . . . **Angie Connor** for her role in the Bureau of Maternal and Child Health and Crippled Children and her contributions to the health care of Hawaii's mentally retarded and handicapped . . . **Unoji Goto** for his many roles; as cardiologist on the first open heart team, his contributions as president of the Hawaii Heart Association, as board member of the American Heart Association, as chief of cardiology, as chief of medicine and then as chief of staff at QMC . . . the late **Nils Larsen** for his role in improving plantation health care, improving the sanitary conditions of Hawaii's milk supply; his role as medical director at QMC and consulting physician for the Hawaii Sugar Planters' Association . . . **Richard K. C. Lee**, former Territorial and then state health director, for his public health activities as chief U.S. representative in the World Health Organization's Pacific meetings, his work in establishing health programs in other parts of the Pacific and finally as director of the University of Hawaii's public health department . . . **Richard Mamiya** for bringing a measure of glory to Hawaii as a nationally recognized heart surgeon and his role as professor of surgery at the UH School of Medicine . . . **Jack Scaff**, for developing the Honolulu Marathon Clinic and starting the Cardiac Rehabilitation Program; for his emphasis in the health rather than the competitive aspects of running . . . **Calvin Sia**, pediatrician, for his continuing efforts to improve health services for children for more than 20 years and as a prominent lobbyist on behalf of children; for his roles with the National Advisory Council on Child Health, with Child and Family Service, with Hawaii Planned Parenthood, with Project Head Start, with the Easter Seal and with the Variety Club schools . . . **Livingston Wong** for his role in Hawaii's Emergency Medical Services program and for his pioneer work in kidney and bone marrow transplants in Hawaii . . . **Robert Worth**, former dean of the School of Public Health, for his studies on leprosy which helped build the case against isolation of leprosy victims and his role in speaking out against Hawaii's isolation policy and in educating the public about leprosy . . .

## Entrepreneurs

The big band sound with "Dr. T and his Torchers" is here to stay. Herein are excerpts from a recent news article on music at The Point After, a favorite nightspot and one of the hottest discos in town: "Probably enjoying the evening as much as anyone else was the band. At first glance, you'd think they were moonlighting engineers, doctors and other professional folk. Yipes! They are! 'Some people like to play golf. I like to play music,' explained 'Dr. T' (**George Takushi**) who is a radiologist by day, a bandleader by night and on weekends . . . Takushi, a member of the original Torchers group back in the 1950's, wanted to get back into music three years ago as an outlet for the tensions of a hectic medical practice. So, he not only rounded up 15 veteran musicians to practice weekly (they now know 350 songs), but built a sound-proof rehearsal hall adjacent to his Portlock home . . . 'This is real relaxation for us.'"

Recent changes in the Civil Rights Act of 1964 have made it possible for the working woman to have 100% coverage starting April 29 in her maternity benefits under health insurance plans. The amendment says it is mandatory for employers with medical plans to provide for "disability due to

pregnancy and related conditions on an equal basis with other medical conditions." HMSA presently pays for 75% of maternity costs, 80% for office calls and 100% for surgery. Henceforth the plan will pay 100% for maternity—a surgical operation . . . As a result, HMSA premiums will rise about 3½% and Kaiser plan rates will rise about 18 cents per month (or .5%).

St. Francis Hospital is constructing a \$6.5 million office building which will be completed in 1980. The four-story, 50,000-square-foot building will have space for about 40 physicians and a two-story parking garage . . .

The Media Institute of Medicine, a non-profit organization established in 1978 to improve medical education through communications, has received a \$78,000 grant from the William Rorer Corp. of Pennsylvania . . . The grant will be used to work with the American Lung Association here to develop the asthma education program, "Winning Over Wheezing."

## Hors De Combat

HEW's "Health-United States, 1978" reports: "The nation's death rate in 1978, as in 1977, was 8.8 per 1,000 persons, an all-time low; yet one death in every eight might have been prevented had there been the appropriate medical intervention . . . Infant mortality in 1976 was 15.2 per 1,000 live births compared with 16.1 in 1975. But half of all women who had babies did not see a doctor during the first three months of pregnancy . . . Thirty-five of every 100 teenagers were sexually active in 1976 compared with 27% in 1971, but only 30 used contraceptives . . . 36% of persons over 40 have never had an EKG to check their hearts. Half of all Americans did not see a dentist in 1977. On the plus side: life expectancy is slowly rising. In 1976, it was 69.7 years for a newborn white male, 64.1 for a non-white; 77.3 years for a white female and 72.6 for a non-white. However, health costs have been rising far faster than any pay-offs in increased health or life and Califano is calling for efforts to increase the health care establishment's 'productivity.'"

Hawaii hospital costs were 11% higher in the final quarter of 1978 than a year earlier (Ed. Bad news), according to the hospitals' Voluntary Cost Containment Committee, but this rate is 6% less than the increase in 1977 (Ed. Good news) . . . Overall yearly rise in costs have been slowed down. In 1977, costs climbed 19.97 % and for 1978, the increase was 13.24%. The voluntary efforts by Hawaii hospitals has resulted in an estimated savings of more than \$1.3 billion. Yet, President Carter has proposed that hospitals either limit increases this year to 9.7% or face mandatory federal price controls. All in vain?

When extensive negotiations failed, the State filed suit in February this year to recover \$190,863 in Medicaid overpayments made to Kida Nursing Home for the period 1966 to 1974. The suit was filed by the recently-formed state Medicaid Fraud Investigation Unit. Deputy Attorney General James Dandar says, "The overpayments were just the result of accounting type errors. There was no attempt to defraud the system."

## Lederle's Human Sexuality Symposium (At Ilikai, Apr. 8— Moderated by Ron Pion)

SEXUALITY . . . WHAT IS IT?

(Notes from talk by Joseph Trainer, Professor of Medicine, Asst. Prof. Physiology, U of Oregon Health Science Center)

I wrote my book, "Physiologic Foundation for Marriage Counseling" on the Kona coast, so I'm no stranger to Hawaii . . . Since most of you are spending your church time here, it may be appropriate to call on the Good Book . . . The problems of sexuality come from "wine, women, and song." Genesis Chapter 11 says "woman came from the rib of Adam"



and blames the apple on the tree for all our troubles, but it was really the "pear on the ground" . . . Genesis Chapter IX says Noah invented wine, that he cultivated the vine, got drunk and lay in his tent . . . His oldest son covered his shame . . .

A couple of gentle old sisters became impoverished and advertised to sell their organ . . . A young man answering the ad came to their door and asked, "Are you the lady selling the organ?" "My sister Amanda takes care of all that." "May I see the organ?" "Come into the parlor, young man . . . We play it all the time . . . Why don't you try it?" Just as the young man was about to play, he noticed a strange sight. On the keyboard was a condom . . . "Excuse me, but what is that?" "That's our good luck charm," Amanda said sweetly . . . "Martha and I went on vacation to the beach and found it on the sand . . . The inscription said, 'To be placed on the organ for the prevention of disease. So we did. And you know, we haven't had a single cold since.'"

As you know, females have two X chromosomes and males have an X and a Y chromosome . . . As males, we are really imperfect females for there is no such thing as a two Y chromosome male . . . And God knows men have a hard enough time surviving . . . They are so fragile . . .

**Developmental Phases:** The most orgasms ever recorded was in a year-old infant . . . **At age 3**, the child is an exhibitionist . . . I was age 4 when a 3-yr.-old girl pulled down her panties to show me her "pee pee" . . . **At age 5**, we are shy . . . You first realize you have to be alone . . . We made mud pies of genitals . . . The ones we made were always larger than in reality . . . **At age 10**, we become self-interested and self-centered. We develop a close friend of our own gender . . . **At puberty**, things begin to change . . . We start producing gonadotropins from our pituitary glands and we have a spurt of growth . . . A terrible surging goes on within us . . . This accounts for the adolescent behavior pattern which is often so fatal to parents . . . From homophilics we become heterophilics . . . Some are never able to make the transition . . . There is an upswing in sexuality . . . Masturbation is taught by our peers, usually only a few years older . . . Girls slide down bannisters and trees and boys find pleasure and guilt with masturbation . . . **During adolescence**, girls become our object of attention . . . Boys are socially and mentally undeveloped, but physically developed . . . According to Kinsey, age 13 is the average age of the boy's first sexual experience which is usually a disaster, but he goes back for another try within 3 weeks . . . The boy's "right of passage" becomes a 6-pack of beer . . . Girls start to menstruate . . . Socially, girls are well put together, but mechanically they are a disaster . . . **Extended Adolescence** (Ages 18 to 20): The young adolescent male is the most expensive, useless creature . . . He then grows up to become a useless adolescent adult . . .

**Quality of Sex Education:** 70% of sex information comes from peer groups . . . Most of which is gross misinformation . . . eg, "When a grown-up couple does it, their temperatures go up to 400° . . ."

**In the Past 20 Years:** The rate of premarital intercourse rose in the male from 80% to 95%; in the female from 41% to 81%. (Thus the female rate is rapidly approaching the male rate.) . . . Since Kinsey, the increase in male sexual activity is twice greater and the female activity three times greater . . . 61% of women under age 25 are on the pill (and not for menstrual regulation) . . . A Danish survey conducted at BYU and Indiana U showed that 19% of the coeds are virgins, 37% have sex with casual friends and 13% have had homosexual experiences . . .

**Marriage Problems:** Early Marriage Period: Most go bad during the first 30 days because of lack of communication and experience . . . Males have a problem with premature ejaculation and impotence while females have a problem with dyspareunia. (There is no case which cannot be treated.)

**Middle Marriage Period:** Herein lie most of the problems . . . Women are preoccupied with children . . . Preoccupied people . . . therefore extramarital sex . . . 85% of men by age 45 and 60% of women by age 45. "How's things at home?" "The old lady is not speaking to me this morning and I'm not in the mood to disturb her . . ."

**Adult-Older Marriage Period:** He goes around with his penis drooping esp. after prostatic surgery . . . Medication

also knocks down his sexual drive . . . He goes to the doctor for some ailment and whatever remaining drive gets knocked out . . . "I treated a minor disease with a major disaster." An 86-year-old man on female hormones for prostatic Ca came in and complained, "Hey Doc, are you giving me anything that affects my sex? I can't cut the mustard more than once a week now." Four months earlier, he had complained of difficulty seeing the signal lights so I had put him on Nicotinic acid 700mg/d. "Do you see the signal lights better now?" "Yeah!" Then I sat down and explained what had occurred . . . "Doc," he said, "The hell with those signal lights!"

## Understanding and Treating Sexual Dysfunctions

(Notes from Beverley Mead's lecture)

Sexual dysfunctions are usually involved with other interpersonal problems . . . ie, it is not simply sexual malfunction alone . . . We still try to use a label because it has some meaning and has a certain emotional impact eg, a "put down" word such as "frigidity" rather than "sexual malfunction."

Sexual malfunction can be organic or functional or a combination thereof (esp. in the middle-aged group). For example, alcohol (organic) creates fears (functional).

How to take a good sexual history: I've tended to give up the sex history form because it is too impersonal . . . A face to face confrontation (or eyeball to eyeball confrontation) is more valuable . . . It desensitizes and discussion is part of treatment itself . . . When the patient has nocturnal erections, then the malfunction is partly functional . . . Try to establish the level of libido . . . It is usually more than the patient would admit to . . . Decreased libido can be caused by depression, testicular loss and aging. There is no loss of libido with neurological damage, diabetes mellitus, and circulatory impairment . . . Drugs either decrease or maintain libido . . . Depression must always be borne in mind with impotence in men and with reduced orgasm in women . . . Women do not have the burden of creating an erection, but her malfunction may be a loss of passion . . . Women may be multiorgasmic when young, but have lesser degrees of spasms when older . . . Functional problems in the male result from fear of failure, fear of aggressiveness, and resentment of his partner . . . In the woman, functional problems result from inhibition, cultural influences, from being overly modest and never having learned responsiveness . . .

**Sex Therapy:** In general sex therapy is so esoteric a thing that anyone who is confidential, judgmental and concerned can do it . . . There has been too much of a mystery re, psychotherapy . . . The basis for psychotherapy: a) a positive relationship, ie, one trusts you; and b) one is a reasonable model of appropriate behavior and rational thinking . . . Psychotherapy is not to be imposed on anyone, but must be a cooperative effort (a team effort). Psychotherapy is what good parents do . . . In sex therapy, even when the dysfunction is only partially removed, then it is successful. Sex in the elderly is valuable for they still need togetherness, sharing and enjoyment of pleasure.

**Treatment:** Remove any removable causes . . . Encourage retraining . . . Always encourage rational reconditioning . . . Work from a base of a non-threatening relation . . . Sex is a very complicated social procedure in our culture and for social standing . . . To be a good lover, one has to be slow, gentle, a little daring, patient, and considerate . . . It has to be an unrecognized conditioning process . . . Sensuality is a marvelous, healthy emotion and should be encouraged and promoted . . . It is vital that we do not confuse emotion with the results of emotion . . . Anger in certain circumstances is normal, but what one does with the anger is important . . . One must relate to a non-threatening partner, ie, not having to apologize or hold back . . . Go ahead and have a good time . . . Emphasize the positive side . . .

**Arousal:** Environment eg, wine, music, etc. is important . . . "Turned-on partner" is the best stimulus . . . Masters and Johnson: "Get third party out of the room . . . Stop thinking about impotence . . . Think only about the partner . . ." Even

with lack of erection, the man can use verbal, oral and finger stimulation . . .

**Causes of Impotence:** a) Concern about physical health: In the post-MI patient, the partner can help tremendously by being the active participant viz doing most of the caressing and activity . . . "If anything should go wrong, she is in excellent position to do CPR;" b) Lack of penetration: The woman partner can assist; c) Premature Ejaculation: Use Squeeze Technique, ie squeeze just hard enough till it softens, then repeat stimulation. The woman takes a more active role, the more responsible role . . . "It's fun to play around—to be able to laugh and be happy about this. Don't be uptight." d) Delayed Ejaculation: Rare in young male; common in middle-aged male . . . How ironic that women need not have an orgasm every time, but we worry about men without ejaculation . . . The woman's role is important . . . Various techniques can be used, eg, *Bridging technique*: ie, masturbate to point just prior to ejaculation and then insert. The problem is more with the wife who feels, "There must be another woman," "He doesn't love me anymore . . ." etc. Female Malfunction: Primary: Never had orgasm; Secondary: Orgasm once but not any more (non-sexual problem) . . . Treatment is the same, ie, re-learning, reconditioning process, desensitizing; focus on what is fun to do; sticking to non-threatening partner; do gradually over a period of time viz slow gradual process. Hormonal therapy: Estrogens do not increase libido in women, but testosterone does in women and in a few men (8 to 10 injections once weekly) . . . Exercises . . .

"We cannot all be grand champions, but you can shoot boggie golf and still enjoy the game."

## Adolescent and Moral Aspects of Sexual Behavior

(Excerpts from Beverley Mead's lecture)

Mankind's hangups on sex are 50,000 years old. When man climbed down from trees, he discovered he could accomplish more with cooperation ie, civilization afforded more comforts and achievements. He discovered that his universal enemy was himself. He set up communities, codes of conduct, taboos, and mores condemning certain behavior. It was easy to set up rules, except in the case of sex . . . esp. with young adults (born with guns, but no bullets allowed till puberty). Sex was condemned as evil, yet sex was important for keeping a tribe strong and numerically superior. Thus, sex became a two-faced emotion. It was condemned on one hand and then uplifted with love and traditions on the other, ie, suppressed in early years and encouraged in later years. It was necessary to suppress till tribal approval or priestly approval was given. Until this century, suppression hardly worked at all. We have come to a sexual revolution and sex is winning. With world overpopulation and with communication and travel made easy, we are now reassessing the moral conduct of sex (ie, moral limits to sex) . . . Morals are important . . . Sex has a tremendous effect on our lives and our emotions . . . Let sex out of our bag of morals? . . . It can't work . . . A popular song of WWI went, "How you gonna keep him on a farm after seeing Paris?" Soldiers were introduced to an eye-opener in society . . . Our youngsters today have even more exposure . . .

Suppression cannot work . . . Instead we should have earlier sex education . . . We should discuss sex with kids of any age. Be comfortable with relating to moral concerns . . . "This is an important human function and it should be exercised with great concern—like any other important human function."

Formerly the deterrent was fear of pregnancy, VD, and reputation . . . These are no longer deterrents because of easy access to contraception . . . We must teach the youngsters to have regard for the feelings and concerns of others . . . This value for the feelings of others should be started earlier in education. Sex education has had too much emphasis on anatomy, physiology, etc. . . . Women develop romantic ideas even before puberty, whereas boys are taught to be muscular, aggressive, manly. Thus women often complain, "My hus-

band takes me for granted." The husband never says this . . . He feels that "I'm a macho man." He fails to recognize her need for not being taken for granted. Sex in women is associated with romantic feelings whereas sex in men is associated with prowess . . . eg, pin-up pictures in girls' rooms are those of an identifiable actor, pretty well-clothed . . . Thought: "You are the girl of my dreams." Pin-up pictures in boys' quarters are those of an unidentifiable woman without clothes . . . Instant action . . . Youngsters do not appreciate the differences of value in boys and girls. Boys throw curved balls to score . . . Girls have other concerns. The "Morning After" pill will upset the physiology for a few days, but it is not as upsetting as a pregnancy . . .

Five common sexual values: 1) Keeping sexual activity in a traditional manner, ie, within marriage; 2) Sex is all right if a/c love and respect; 3) Sex as a recreation—as long as no harm is done—sex is fun; 4) Sex is frankly exploited—To get money, to get ahead in life; 5) Open marriage—value system—allowed certain freedoms as long as partner consents . . .

To avoid conflict, both partners should be in the same category . . . **Adolescent Behavior:** Masturbation still creates hangups in a few. It is now regarded as normal and accepted as part of development . . . Successful masturbation leads to successful marriage . . . Ten usual questions we are asked:

1) My daughter is having an affair: Don't challenge . . . Talk to her, assuming she is having an affair . . . Talk about avoiding pregnancy . . . Don't try to impose your own values on her. Do not be judgmental. Tell her that you love her and that you are concerned . . .

2) I already told her it is so: Don't make it a point of contention . . .

3) My son is hanging around strange guys: Fear that he may be homosexual. Don't confront or be judgmental . . . Make it easy for him to confess . . .

4) I've got a friend with a problem: Don't embarrass . . . Be concerned . . . They are concerned and fearful of your attitude . . .

5) Girl: Will riding a bicycle keep me from getting pregnant? Answer: As long as you stay on the bike.

6) Why does my daughter behave that way? That is not the way we brought her up . . . The adolescent needs to assert her identity . . . Identifies with her peers. Have to feel like someone . . . Sexual activity is an acting out. "Better to be a bad somebody than a good nobody."

7) Peeping Tomism: Early adolescent activity. Majority of boys do it. Girls do not. "Listen son, it is a dangerous thing. Someone may blow your head off."

8) Exhibitionism: Prevalent between ages 14 and 18. A male activity. Done to shock and dismay. Same psychology as the obscene phone caller. Indication that the kid needs attention, and has resentment about the world.

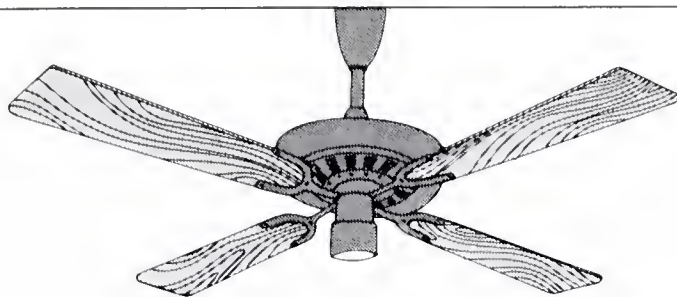
9) A teenager asks for the pill: Yes, I will give it. Don't quibble . . .

10) Doctor, what's happening to this generation? Is it TV, drugs, etc.? Future shock theme. More is demanded of us . . .

## Our "Angels"

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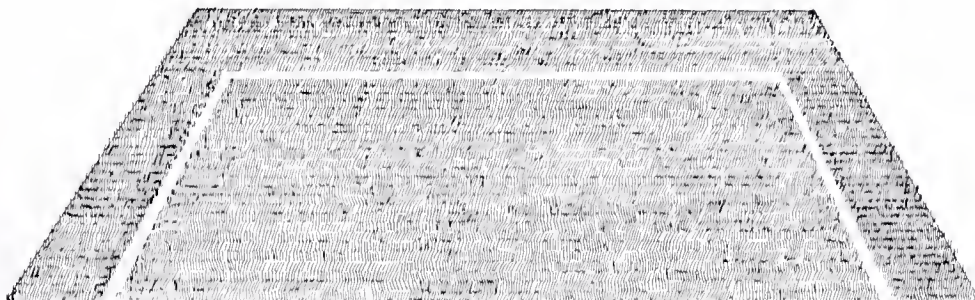
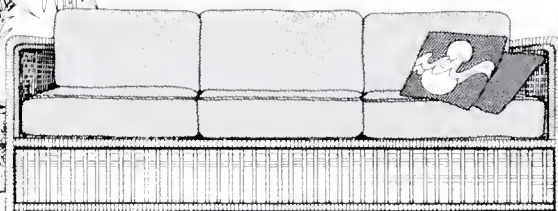
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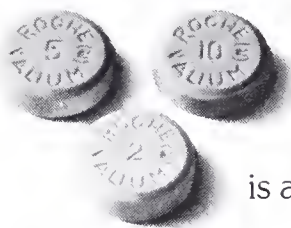
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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,  
8th Edition, 1977, McGraw-Hill, p. 900.





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**Reference:** Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969

# The Maker

## Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



*MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.*

**FACT:** The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

*MYTH: Industry favors only "expensive" brand names and denigrates all generics.*

**FACT:** PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



# Matters.

**MYTH:** Generic options almost always exist.

**FACT:** About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

**MYTH:** Generic prescriptions are filled with expensive generics, thus saving consumers large sums of money.

**FACT:** Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

**MYTH:** Drugs account for a major portion of the rise in health care costs.

**FACT:** Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

**MYTH:** Government intrusions into the marketplace will save tax money.

**FACT:** Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

## The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

## The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



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gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

[102175]

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*Are A and B hepatitis viruses more common in Hawaii than in the U.S. generally?*

# Prevalence of Antibodies to Hepatitis A and Hepatitis B in a Hospital Population

RICHARD WASNICH, M.D., DUDLEY S. J. SETO, M.D., FRANCIS FUKUNAGA, M.D., FANG-MEI YEH, M.S., and BOBBIE KAWAMURA, M.L.T., *Honolulu*

Recent developments in viral hepatitis research have resulted in a new array of sometimes bewildering diagnostic tests.

Antibody to Hepatitis A virus (anti-HA) can now be measured by radioimmunoassay techniques, and this has proved useful in epidemiological studies. Because of its high prevalence in the general population, the usefulness of this measurement in individual patients is limited unless rising titers can be demonstrated.

Hepatitis B can now be characterized by several antigen systems, including surface antigen (HB<sub>s</sub>Ag), antibody to HB<sub>s</sub>Ag (anti-HB<sub>s</sub>), core antigen (HB<sub>c</sub>Ag), antibody to HB<sub>c</sub>Ag (anti-HB<sub>c</sub>), e antigen, and e antibody. Tests for these antigen systems have greatly enhanced the understanding of hepatitis B and diminished the frequency of post-transfusion hepatitis. However, Hepatitis B remains a significant public health problem; it occurs with disturbing frequency in certain hospital departments, notably hemodialysis units, and thus represents a hazard both to personnel and to other patients.

We are reporting results of various new hepatitis tests among general hospital patients and personnel.

## Methods

Measurement of HB<sub>s</sub>Ag was made by solid phase radioimmunoassay (Ausria II, Abbott Laboratories, North Chicago, Illinois). Anti-HB<sub>s</sub>Ag was also measured by solid phase radioimmunoassay (Ausab, Abbott Laboratories). Results of both procedures are expressed as a ratio of sample counts per minute to a negative control mean counts per minute. Any sample

yielding a ratio greater than 2.1 is considered positive.

Anti-HB<sub>c</sub> was tested for by a solid-phase competitive-inhibition radioimmunoassay (Corab, Abbott Laboratories). A cutoff value is determined by the formula:

$$\frac{\text{NCx} + \text{PCx}}{2} = \text{cutoff value}$$

NCx is the negative control mean and PCx is the positive control mean. Samples having counts equal to or less than the cutoff value are considered positive. Quantification of anti-HB<sub>c</sub> was arbitrarily expressed by the formula.

$$\frac{\text{NCx}}{\text{Sample Cx}} = \text{Ratio}$$

Anti-HA testing was performed by competitive-inhibition radioimmunoassay (HAVAB, Abbott Laboratories). A cutoff value is determined by the formula:

$$\frac{\text{NCx} + \text{PCx}}{2} = \text{cutoff value}$$

NCx is the negative control mean and PCx is the positive control mean. Samples with counts equal to or less than the cutoff value are considered positive for anti-HA.

## Results

A total of 200 consecutive hospital admissions were tested for the presence of anti-HA. Of these, 139 (67%) possessed anti-HA. Among 100 patients consecutively admitted and tested for HB<sub>s</sub>Ag and anti-HB<sub>s</sub>, 2 HB<sub>s</sub>Ag carriers (2%) were discovered. Anti-HB<sub>s</sub> was found in 28% of hospital admissions.

A series of 79 consecutive new employees were tested for HB<sub>s</sub>Ag, and 3 (3.8%) carriers were discovered.

When patient and personnel data are combined, there are 5 HBsAg positives among 179 subjects, or 2.8%.

Some 50 units of packed red cells were tested for anti-HB<sub>c</sub>. All of these units had previously tested negative for HBsAg, but 6 units (12%) were positive for anti-HB<sub>c</sub>. All but one of these units was negative for anti-HB<sub>s</sub>.

All hemodialysis employees are routinely tested for HBsAg, anti-HB<sub>s</sub>, anti-HB<sub>c</sub>, and anti-HA. Newly employed personnel with HBsAg are not assigned to the hemodialysis unit. No HBsAg conversions have been detected during the past four years of monitoring. Of 23 dialysis employees, 5 (15.2%) possess anti-HB<sub>s</sub>; conversions have been discovered during the past 2 years of monitoring, and are the subject of continuing investigation. Of 29 employees examined, 7 (24.1%) possess anti-HB<sub>c</sub> and 4 (13.8%) possess anti-HA.

### Discussion

Hepatitis A is most commonly transmitted by the fecal-oral route, either by direct person-to-person contact or in contaminated food or water. The hepatitis A virus (HAV) is only briefly present in serum during the pre-icteric stage of the illness, but disappears soon after the onset of jaundice. Therefore, parenteral transmission is fairly unusual. It is also difficult to isolate HAV from serum, because of the short duration of the viremia and its low titer.

However, Hepatitis A infection does result in early production of antibody (anti-HA), which can now be measured by radioimmunoassay. Although measurement of anti-HA is useful for epidemiologic and screening purposes, it is less useful in the diagnosis of acute Hepatitis A in an individual patient.

Our results indicate that 67% of the population in Hawaii already possess anti-HA. This contrasts with a prevalence of 45% in the greater New York City area, as reported by Szmuness.<sup>1</sup> The New York study also demonstrated anti-HA more frequently in lower social classes (72 to 80%) than in upper-middle classes (18 to 30%). Szmuness also found anti-HA prevalence to correlate significantly with age and serologic evidence of past exposure to Hepatitis B virus, but was independent of sex and race. Very few of the New York subjects had a history of clinical hepatitis.

Because of the high prevalence of anti-HA in the population, a single assay is of little clinical use unless rising titers can be demonstrated by serial measurements. Of further interest is the fact that the early anti-HA associated with acute illness is primarily of the IgM class, which declines in titer during convalescence and may be undetectable a few months later.

The convalescent antibody is primarily of the IgG class and it is the IgG anti-HA which is found

in the sera of previously infected individuals and is associated with long-term immunity.

The RIA method used in this study does not differentiate the IgG and IgM classes. Recent modifications of the RIA procedure may permit differential measurement of the two anti-HA antibody classes.

### Discussion—Hepatitis B

Hepatitis B is characterized by several different antigen-antibody systems. Hepatitis B surface antigen (HBsAg) appears in the serum prior to the onset of clinical illness and usually disappears during convalescence, but it may persist to produce a chronic carrier state and chronic hepatitis. Approximately 0.5% of the U.S. population are chronic HBsAg carriers, and are considered infectious.<sup>2</sup>

The prevalence of HBsAg is known to be quite high in Asia, and therefore a higher prevalence would be anticipated in Hawaii. Of our 100 consecutive hospital admissions, 2.0% were HBsAg carriers. Lewis et al.<sup>3</sup> previously reported that 0.8% of medical personnel in Maryland were HBsAg carriers, as contrasted with the 3.8% of hospital employees in our study. Thus HBsAg appears to be more common in both medical and non-medical subjects in Hawaii, as compared with the U.S. mainland.

Antibody to HBsAg (anti-HB<sub>s</sub>) is usually detected late in convalescence, and may persist for many years. Its presence is indicative of prior exposure to Hepatitis B virus (HBV), and nearly always indicates recovery and immunity to reinfection.<sup>4</sup> Anti-HB<sub>s</sub> has been found in 15 to 25% of young, urban U.S. adults. Similar figures have been reported for physicians (18.5%).<sup>4</sup> There appears to be a higher prevalence (30-45%) in lower socio-economic groups.<sup>6,7</sup> In our study, 28% of hospital admissions possess anti-HB<sub>s</sub>, which is only slightly higher than the 15-25% reported on the mainland. Based on the higher prevalence of HBsAg in Hawaii, a higher figure for anti-HB<sub>s</sub> was anticipated. In fact, among our hemodialysis personnel, only 15.2% possess anti-HB<sub>s</sub>. The immune response to HBV is well-known to be genetically-determined, which is one possible explanation for this apparent discrepancy.<sup>8-15</sup> The unexpected high prevalence of anti-HB<sub>c</sub> in our population, as discussed below, may also be a manifestation of a genetically-variable immune response to HBV.

The core of the Dane particle possesses a different antigenic specificity (HBcAg). In contrast to anti-HB<sub>s</sub>, anti-HB<sub>c</sub> appears in serum during the acute stage of the illness. Although the significance of anti-HB<sub>c</sub> is not fully established, it does not appear to be protective against HBV.<sup>16</sup> It has been suggested that anti-HB<sub>c</sub> reflects on-going HBV replication and that it therefore may be a more sensitive indicator for



HBV than the measurement of HBsAg.<sup>16</sup>

We have found anti-HBc in 12% of blood donor units which were negative for HBsAg. This is considerably higher than the 1% reported by Hoofnagle et al. in 200 HBsAg-negative blood donors.<sup>17</sup> This is of particular interest, in view of recent reports indicating that blood units containing anti-HBc, but negative for HBsAg, are capable of transmitting Hepatitis B to blood recipients.<sup>18</sup>

In addition, a recent report from Omata et al.<sup>19</sup> has demonstrated that patients with only anti-HBc in serum, and without anti-HBsAg or HBsAg, have a very high incidence of tissue HBcAg present in liver specimens taken at autopsy. In fact, Omata found that 100% of such patients possess Hepatitis B core antigen in their livers. In addition, 2 of 5 patients with both anti-HBc and anti-HBs had liver HBcAg, whereas none of 26 subjects with only anti-HBs had HBcAg in liver. Although these findings confirm that the presence of anti-HBs only is compatible with resolution of prior Hepatitis B infection, they also for the first time show that high-titers of anti-HBc, even with the co-existence of anti-HBs, are indicative of ongoing Hepatitis B replication in the liver.

Of the 5 known recipients of anti-HBc-positive blood in our study, none had apparent clinical hepatitis. None have been tested for sub-clinical hepatitis or seroconversion. However, in

view of the recent findings concerning the significance of anti-HBc, and the fact that Hepatitis B transmission by blood transfusion continues to occur, measurement of anti-HBc in blood donors may prove to be useful, especially if it proves to be as prevalent locally (12% in blood donors) as our initial results indicate.

The high prevalence of anti-HBc in our blood donor population is somewhat in contrast to our anti-HBs prevalence, which appears to be similar to U.S. mainland figures. We have also found anti-HBc to be more prevalent (24.1%) than anti-HBs (15.2%) among our hemodialysis employees. It is known that anti-HBc may persist in the serum long after anti-HBs has disappeared, and this may be the explanation for the lower prevalence of anti-HBs among hemodialysis employees. However, the generally higher prevalence of anti-HBc in our blood donor population, as compared to mainland figures, may also be a manifestation of genetically-variable host factors in our population, such as immune response. In any case, it indicates that chronic Hepatitis B infection is considerably more prevalent in Hawaii than on the U.S. mainland.

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# Initial Experience With The First Whole Body Computerized Tomography Scanner in Hawaii

RAYMOND W. BRUST, JR., M.D.,\* *Honolulu*

● In June 1976, the Hawaii State Comprehensive Health Planning Commission granted certificates of need to St. Francis Hospital and Kapiolani-Children's Medical Center for whole body computerized tomography scanners. The first such scanner was installed at St. Francis Hospital in May 1978. This report will present the first 6 months' experience with this initial whole body CT scanner in Hawaii.

The whole body CT scanner purchased by St. Francis Hospital (and also by Kapiolani-Children's Medical Center) was the Ohio Nuclear series 2010, a rotational so-called 4th generation scanner. This unit is capable of performing both head and body area scans in speeds varying from 2 to 8 seconds.

A selection of the standard x-ray factors of Kv, ma and filtration is available as well as variable thickness of the scan slice from 4mm to 10mm. The gantry diameter, 50cm, has accommodated patients weighing over 300 pounds. A forward and backward gantry tilt of 20° allows coronal sections to be obtained.

A region of interest control allows direct reading of Hounsfield numbers (related to x-ray attenuation values of tissue) for areas of any size on the scan, along with statistical parameters. Direct millimeter measurement of any structure or interval between structures on the scan can also be obtained.

In the body, the scans are cross-sections and are displayed with the patient's right on the viewer's left, like conventional radiographs.

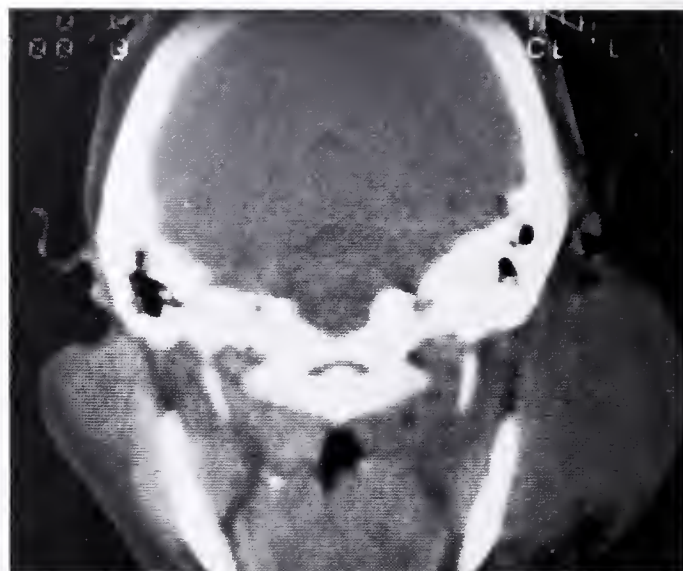
Since the first patient was scanned in May 1978, 900 patients had been scanned through December, 1978. Head scans accounted for 60%, while 40% were body scans. Of the total patients, 786 were from St. Francis Hospital, including private out-patients, and 114 patients were re-

ferred from other hospitals, chiefly in the Honolulu area. One patient was sent from a neighbor island. The scanner is operational on a scheduled basis of 5½ days a week and on a 24-hour emergency basis. Approximately 3% of the scans were emergency cases, all head scans. The "down time" of the machine averaged 2½ days per month.

## Head Scans

Since other head CT scanners are in use in Hawaii, only brief mention of head scans with the whole body CT scanner will be made. The head scans done with the whole body unit are comparable to those of standard head scanners. The ability to perform scans in 2 seconds offers obvious advantages in difficult patients. Coronal section scans have proven useful on several occasions, particularly in midline head lesions and in the face (Fig. 1).

FIG. 1.—Coronal scan of a parotid tumor (arrow) showing the relationship to adjacent bony and soft tissue structures of the face.



\*Department of Radiology, St. Francis Hospital, Honolulu  
Accepted for publication March, 1979.



## Body Scans

Of the body scans performed (Table 1), the majority were abdominal (269), followed by spine (59) and thorax-neck (32). Slightly less than half of the abdominal scans were of the pancreas.

TABLE 1.—Body Scans with the Whole-Body CT Scanner

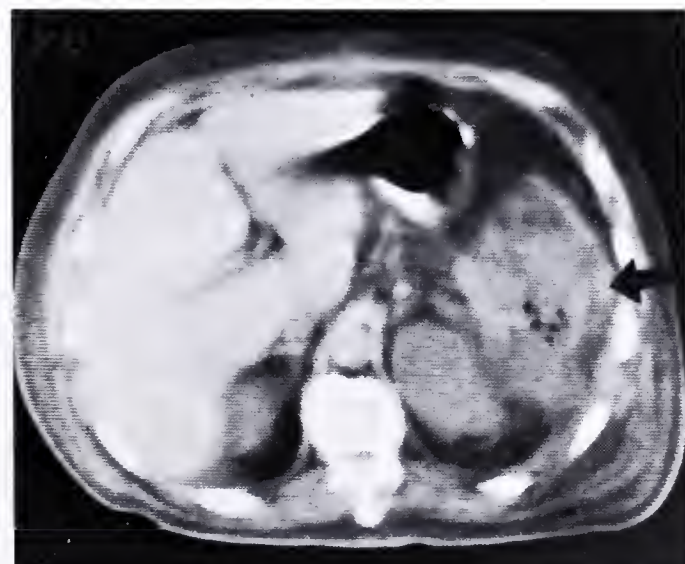
BODY REGION	NO. OF CASES
Peritoneum	24
Retroperitoneum	44
Liver-spleen	32
Renal	18
Adrenal	9
Pancreas	117
Pelvis	24
Spine	59
Musculo-skeletal	4
Neck	6
Lung-pleura	13
Mediastinum	13

No special patient preparation was found necessary for abdominal scans. However, retained barium in the intestinal tract presented considerable artifact. Due to the fast scan speed, respiratory and intestinal motion presented no problems.

Water soluble gastrointestinal contrast was usually given prior to scanning to readily identify these structures. Occasionally, intravenous contrast medium was given to establish the vascular nature of a structure or to differentiate a cyst from a solid mass.

**Peritoneum.** Examination of the peritoneal cavity was done primarily in search of abscesses, chiefly in the upper abdomen. The location and extent of an abscess (Fig. 2) could be ascertained and provided valuable pre-operative information.

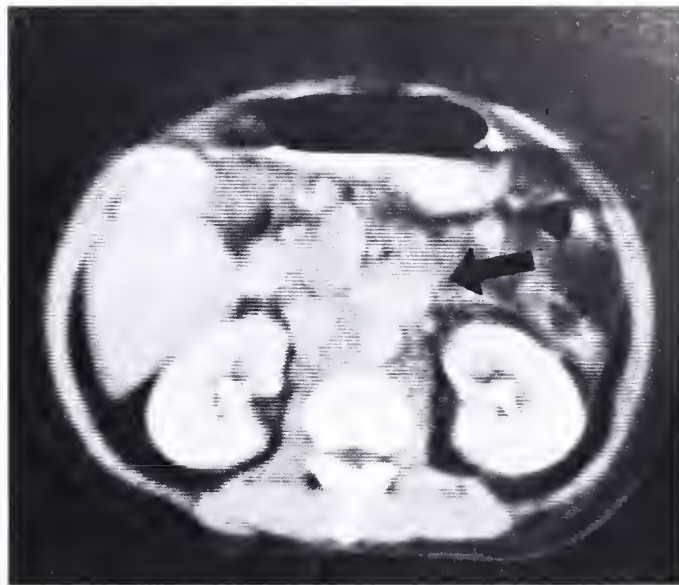
FIG. 2.—Post splenectomy abscess (arrow) extending inferiorly into the perirenal space.



**Retroperitoneum.** Diagnosis and staging of lymphomas was the main reason for studying the retroperitoneum. The detection of enlarged paraaortic nodes and often associated mesenteric

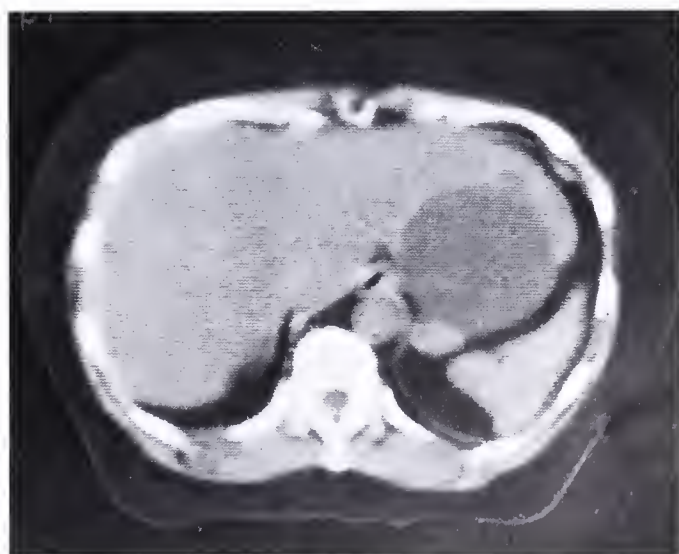
adenopathy (Fig. 3) presented no difficulty. Similarly, enlarged metastatic nodes, abscesses, and retroperitoneal tumors were clearly seen on the scans.

FIG. 3.—Extensive mass of para-aortic and mesenteric lymph nodes (arrow) in a patient with lymphoma.



**Liver-Spleen.** Space-occupying lesions of the liver, biliary tract obstruction, and fatty metamorphosis (Fig. 4) were demonstrated on scans of the liver and spleen. Additional sections through the liver were usually obtained if a neoplasm of another organ was seen (eg, pancreas). On occasion, a CT scan was requested to clarify findings on nuclear medicine liver-spleen studies.

FIG. 4.—Low density liver of fatty metamorphosis with a large simple cyst in the left lobe.



**Kidney.** A limited number of renal scans were done, mainly to help resolve questionable cases of cyst vs. neoplasm studied by other means. Demonstration of abscess and the extent of neoplasm was also provided in a few cases.

**Adrenal.** The adrenal glands are clearly depicted by the scanner and several vasoactive tumors were demonstrated, obviating potentially hazardous angiography. A case of metastasis to the adrenal from the lung was also seen (Fig. 5).

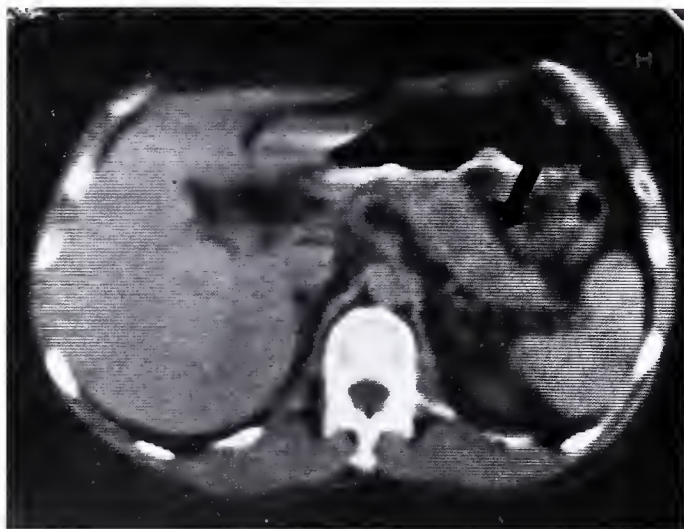


FIG. 5.—Magnification scan of the right adrenal showing a metastatic tumor (arrow) from the lung.



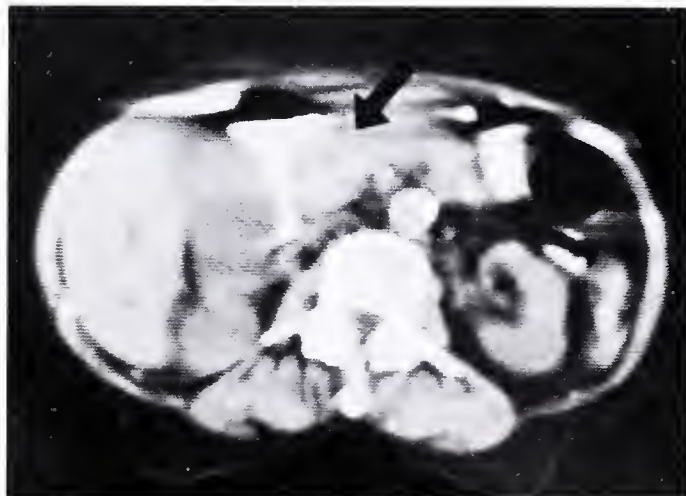
**Pancreas.** Our most frequently performed abdominal scan was the pancreas. Except in very thin patients, the entire gland was well seen. Documentation of acute pancreatitis (Fig. 6), pseudocyst or abscess formation could be made.

FIG. 6.—Scan of the pancreatic region showing an enlarged low density body and tail portion (arrow) in a patient with clinical diagnosis of acute pancreatitis.



Carcinoma of the pancreas (Fig. 7) presented as a focal enlargement especially in the head portion.

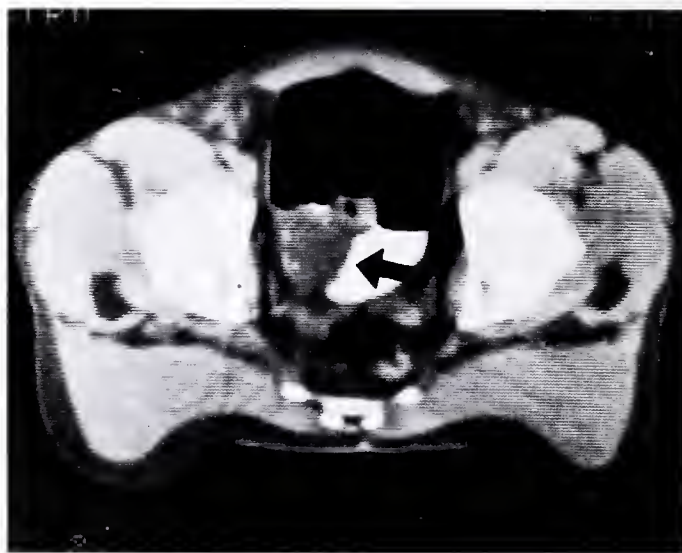
FIG. 7.—Enlarged head of the pancreas (arrow) due to carcinoma. Note also the enlarged low density gall bladder and dilated bile ducts in the liver.



Associated biliary tract obstruction and liver metastasis could be appreciated in several cases. Some scans were requested to elucidate questionable findings on ultrasound, particularly in the body and tail portions of the pancreas.

**Pelvis.** Most of the pelvic scans were done on women. Scans of the female pelvis required more patient preparation to facilitate distinguishing the various pelvic viscera. CT scans were found helpful in assessing the stage of cervical carcinoma and in documenting recurrent pelvic tumor in both women and men. We had the opportunity to assist in the staging of 2 cases of male bladder carcinoma (Fig. 8) with the double contrast method of Seidemann *et al*<sup>1</sup> with promising results.

FIG. 8.—Double contrast staging of a bladder carcinoma (arrow) showing no extension to seminal vesicles (Stage B).



**Spine.** Suspected lumbar spinal stenosis was the most common reason for scanning the spine. Although this diagnosis was confirmed in few cases, its exclusion provided valuable information.

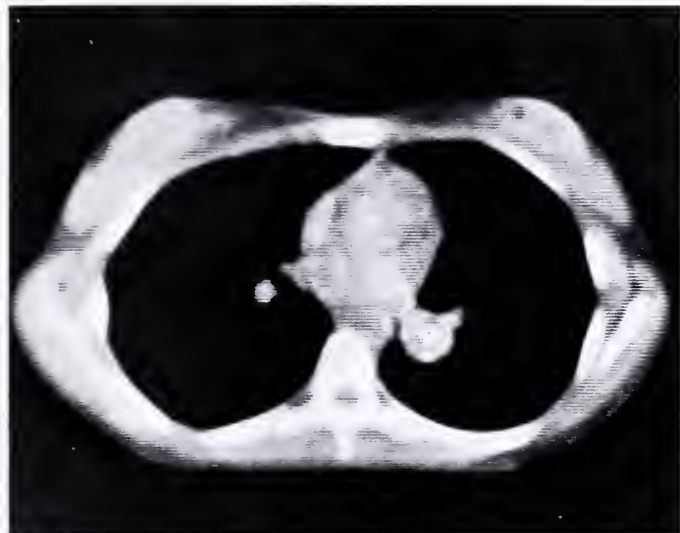
**Musculo-skeletal.** A few extremity scans were done, chiefly to show the extent and anatomic relationship of tumors. A specific type of tumor could be established in the case of lipomas.

**Neck.** Similar to the extremities, the few cases of neck scans performed were helpful in showing the extent and relationships of masses involving the pharynx, larynx, and other structures.

**Lung-Mediastinum.** An equal number of lung and mediastinal scans were done. Lung scans were used chiefly to determine the extent of tumors and in detection of metastatic nodules. In the latter case, CT scans have been found to be more sensitive than conventional radiologic techniques.<sup>2</sup> An initial few cases of suspected asbestos exposure were scanned, demonstrating calcified pleural plaques, which have been reported to be demonstrated earlier than on plain radiographs.<sup>3</sup> Mediastinal scans yielded much useful information. Specific tissue determination of masses as fat, cystic (Fig. 9), or vascular could be made. Cases with questionable hilar tumor or



FIG. 9.—Mediastinal scan of a bronchogenic cyst with region of interest cursor in the center and calcium about the periphery of the cyst.



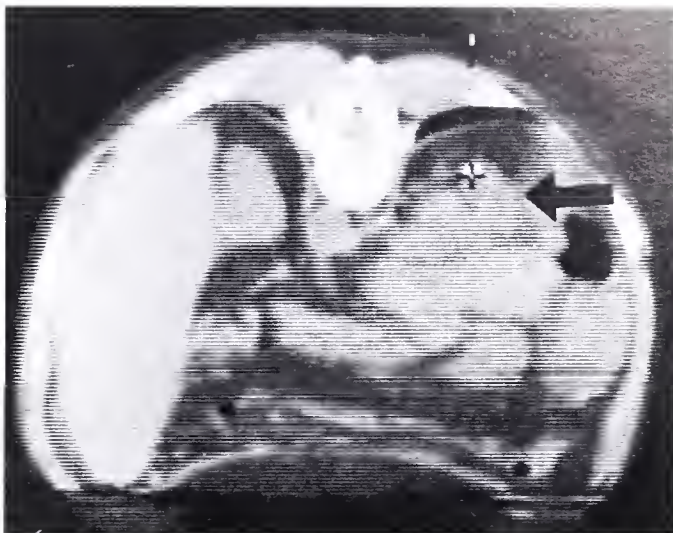
adenopathy were readily resolved with CT scanning.

**Biopsy.** In one case, a CT-scan-assisted percutaneous needle biopsy was performed for suspected recurrent renal carcinoma (Fig. 10), proven positively. CT scanning would seem to be well suited to this procedure, as the localization and the distance to a suspected lesion can be quite accurately determined.

### Summary

The initial experience with a whole body CT scanner in Hawaii has already yielded a good deal of valuable diagnostic information in patient care. It has proven most helpful in the body

FIG. 10.—CT-assisted biopsy with measuring markers in place on the skin and at level of suspected recurrent renal cell carcinoma (arrow) The patient is prone.



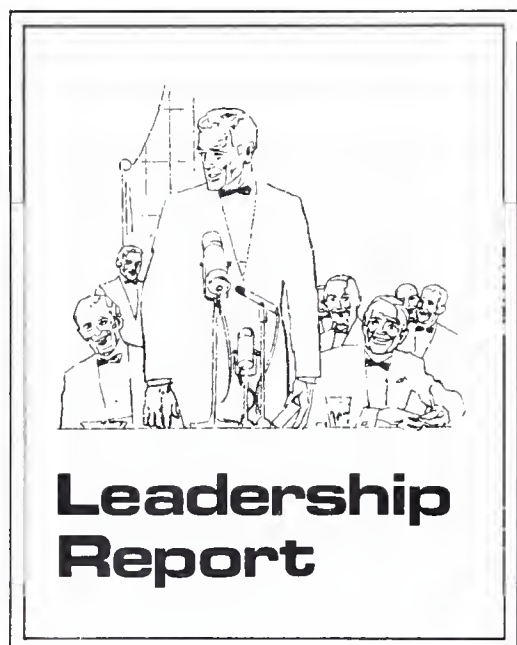
regions in which conventional radiologic techniques have been difficult and frustrating, particularly to elucidate retroperitoneal organs and structures. On many occasions, diagnostic dilemmas have been resolved without the need for a multiplicity of diagnostic imaging studies. It would appear that the whole-body CT scanner has much to offer as a diagnostic modality in the health care of the people of Hawaii.

### Acknowledgment

The author wishes to thank Frank Gamundoy R.T., Carole Robinson R.T. and Sharon Langton R.T. for their technical assistance and Kay Doi for secretarial assistance.

### REFERENCES

1. Seidemann FE, Cohen WN, Bryan PJ: CT staging of bladder neoplasms. *Radiol Clin North Am* 15:419-440, 1977.
2. Muhm JR, Brown LR, Crowe JK, et al: Comparison of whole lung tomography and computed tomography for detecting pulmonary nodules. *Am J Roentgenol* 131:981-984, 1978.
3. Kreel L: Computer tomography in the evaluation of pulmonary asbestosis. *ACTA Radiol (Diagn)* 17:405-412, 1976.



## Leadership Report

JON WON

### HMA COUNCIL HIGHLIGHTS May 4, 1979

**The Community Cancer Program of Hawaii** and the HMA have been pursuing the development of four or five programs to be subcontracted to the HMA for the next year or two. Programs considered were: (1) administrative handling of a course for radiologists to become A and B readers; (2) colonoscopy/sigmoidoscopy training enhancement program for medical students, housestaff, and some practitioners; (3) medical cancer information line with prerecorded tapes for physicians and other professionals; (4) publication and some development of Hawaii outlines for cancer management; and (5) development of a medical providers' personal cancer control program. The time frame has been extremely tight and the proposals for such a subcontract were not complete. The Council expressed some concerns over the development of the needs assessment for each of these proposed projects and referred this program back to the Cancer Committee for further study. It should be noted that the HMA Cancer Committee met four days after Council and generally felt that the development of the proposed programs and the needs assessment were not sufficient to warrant any recommendation.

**The Public Affairs Committee** reported that it was attempting to develop interest in our TV series, "Your Body, Your Mind," through meetings with foundations, trusts, and other funding organizations. A fifteen-minute promotional tape using excerpts from past programs was presented. This tape is used to present to such funding organizations. The tape is well done, and the TV-Radio Committee should be proud of its accomplishments.

**The 1981 Hawaii Health Fair**, to be run and sponsored by the HMA, has been tentatively set for the Fall of 1981. Announcements and expressions of interest forms will be sent out shortly

to previous (1968) exhibitors and other interested organizations. The 1981 Health Fair still needs a chairman but there are a number of possibilities in the making.

**The 1979 Legislature is over**, but the effects and ramifications of this year's Legislature have yet to reach full impact. The HMA Legislative Committee, under Dr. E. Lee Simmons, has sent to each HMA member, a summary of the successes and failures of the 1979 Legislature with a brief analysis (Legislative Update). The two bills which were closely watched this year by the HMA was the Medicaid Bill (H.B. 605) and the Minors' Rights Bill (H.B. 520). The Medicaid Bill left physicians' reimbursement for Medicaid patients at the 1975 level; the Minors' Rights Bill adds family planning to the services that a minor can consent to. Both are now awaiting the Governor's signature. If you feel strongly regarding these issues, we urge you to express yourself to the Governor to either sign or veto these measures.

**THE HMA-EMS Program** is trying to get the Board of Medical Examiners to begin a program of certifying paramedics. The HMA feels that since paramedics are really extensions of physicians, the body that licenses physicians should be the certifying agency for paramedics.

### AMA HIGHLIGHTS

**A Checklist on Hospital Cost Containment** was sent last week by the AMA to the chief of medical staff of every hospital in the nation as part of the Voluntary Effort to hold cost increases to 11.6% in 1979. The checklist was prepared by the AMA at the request of hospital chiefs of staff with the assistance of VE coalition members and representatives of California, Pennsylvania and Texas medical and hospital associations.

In a letter accompanying the checklist, AMA EVP James H. Sammons, MD, points out that increased utilization was a significant factor in rising hospital expenditures early this year. The checklist outlines specific ways in which chiefs of staff can (1) provide professional participation in cost containment programs to assure quality care, (2) encourage physicians to make their practices more cost-effective and to make more effective use of hospital facilities, and (3) make changes in medical staff activities to assure more efficient use of hospital personnel, supplies and equipment.

**The Blue Cross and Blue Shield Associations** recommended that member plans pay for routine hospital admission tests for surgical patients only when the tests are specifically ordered by physicians. A similar policy was handed down in February regarding routine admission tests for non-surgical patients.

The need for specific physician ordering of admission tests for surgical patients was endorsed by the American College of Sur-



geons. C. Rollins Hanlon, MD, director of the ACS, accompanied Blues' President Walter J. McNerney at a Washington, D.C. news conference announcing the new policy.

McNerney said about 45% of hospital admissions are surgical patients and their testing costs about \$1.1 billion annually. The new reimbursement procedures will get underway in about a year. He said there has been "very good" cooperation by physicians and hospitals with the Blues' plans to tighten test procedures.

**AMA Membership was 211,000 Last Year.** The figure includes 179,400 dues-paying members, an increase of 5,900 over 1977. Others in the total are affiliate members and dues-exempt members, the latter being primarily retired physicians.

The number of physicians paying full dues in 1978 was 147,700. Resident physicians, who pay partial dues, numbered 16,300. Medical students, who also pay partial dues, totaled 15,400. In 1977 there were 173,500 dues-paying members—146,600 full dues, 13,400 residents, and 13,500 students.

"The only bright spot in these figures is the rapidly rising number of young members—the 31,700 interns, residents and students," said AMA EVP James H. Sammons, MD. "That's a 759% increase since 1973, when combined regular membership in these categories began. These young people now make up 18% of our dues-paying membership, and their involvement now means much for the AMA's future."

In all other respects, Dr. Sammons said, "AMA membership is not what it should be. We are making gains at a time when many national associations and almost all labor unions are losing members, but the number of full dues-paying members is not rising proportionately with the physician population. Thousands of physicians are 'free riders,' letting their colleagues pay the bills for the national leadership—and survival—of their own profession."

**A List of Therapeutically Equivalent Drugs** prepared by the Food and Drug Administration represents a reversal of the FDA's role as watchdog of the drug marketplace and should be withheld from official distribution, the AMA told the agency. The list identifies drugs "approved" under the Federal Food, Drug and Cosmetic Act, and designates multisource drugs that the FDA has decided are "medically equivalent to the brand-name products of other manufacturers." The AMA pointed out that the FDA concedes that it has made judgments on "therapeutically equivalent" drugs despite the lack of bioavailability or bioequivalence testing and assessments in FDA files.

The AMA noted that the FDA, in its announcement of the list, makes strong disclaimers "to remove from its shoulders any

responsibility for any untoward consequences" as a result of reliance on FDA judgments. The FDA's numerous "exceptions, exemptions and rebuttal presumptions" leave the list on shaky grounds, the AMA said.

**The AMA Urged Congress to Increase Funding** for 13 programs that "hold the greatest promise for improving our nation's health." In letters to the chairmen of key Congressional committees, the AMA said it was limiting its recommendations for increased appropriations in fiscal year 1980 because of inflation in the general economy and the need to control deficit spending. "We are working with Congress to develop legislation that will focus on positive health strategies as well as health program cost reductions," the AMA said. "The challenge is to act with fiscal constraint and responsibility, while making sure our federal tax dollars are spent in the best possible way."

The AMA recommended that funding be increased beyond President Carter's budget request by \$613.4 million, with the largest increases going to the National Institutes of Health (\$227.6 million) and health professions education (\$143.4 million). More money also was recommended for maternal and child health, family planning, emergency medical services, venereal disease control, immunization, childhood lead-based point poisoning prevention, health education, mental health, alcoholism, aging, and the Food and Drug Administration.

**An HEW Proposal Contradicts the Administration's** theme of hospital cost containment and violates the President's executive order on "simple and clear" regulations, the AMA charged. In comments on a proposed System for Hospital Uniform Reporting and its 600-page draft manual, the AMA told the Health Care Financing Administration:

"To impose a new, extensive system, which is of questionable benefit and where the full costs are uncertain, is unjustifiable in this period when hospital costs are already under attack by the Administration and when government regulation is already identified as a substantial cause of such increasing costs."

**HEW Spent \$108,678** on its 25th birthday celebration last year. At the time of the occasion, last May 23-24, HEW reported \$15,000 as the celebration expense. The larger figure was released after the Associated Press made inquiries.

## A NOTE OF APPRECIATION

... received April 23, 1979:

"Dear Dr. Goto,

My sons and I have appreciated the overwhelming expressions of Aloha from so many of

Felix's friends and colleagues. Your letter on behalf of HMA, and the donation made in memory of Felix came to us so quickly after his passing. Thank you for your kind words. Felix loved life and medicine. I am proud that he was a part of the Hawaii Medical Association. He shared his life with all of us to the fullest, and our pain is still acutely felt. Be assured that he was involved in organized medicine because he *believed* in it.

Please express our sincere gratitude to the membership.

(signed) Jewel Lafferty"

#### ANOTHER LETTER

... received by the Peer Review Committee of Honolulu County Medical Society that was sent to a member of our Society by a patient that the Peer Review Committee chairman felt should be shared with the membership:

"Dear Dr. -----:

I received your letter and read it with great interest. Why? Because I had come to the same conclusion a few days before receiving your letter. At that time I was composing a letter of complaint to the Hawaii Medical Association. I tried hard to make my point clear to them why I felt it was an unfair practice to charge as your office did, and as you agreed was correct, my notes only convinced me I was wrong. I discussed this matter with my wife and we both felt that I should forget my complaint and tell you so on my next visit with you. You are right and I was wrong in this matter. Thank you for taking your time to explain by letter your system of charges. I understand it now and Mahalo."

**Internist or Family Practitioner Wanted.** Interested physicians contact Dr. Bell at 941-5085.

**Announcement:** "First National Conference on Antibiotic Review: West Coast Update;" Bonaventure Hotel, Los Angeles, California, September 10-11, 1979. Contact: Muriel Myers, Suite 113, 67 Peachtree Park Drive, Atlanta, Georgia 30309.



#### Insomnia, Anyone?

I met a psychiatrist last month who is really interested in patients with migraine headaches, and he claims to get gratifying results; I'm going to send him some. The other day I learned there's an orthopod who actually enjoys seeing people with chronic backaches, and there's an ENT man who collects cases of longstanding vertigo.

Someone heard of a doctor who likes to see chronically depressed patients, and there's an internist who enjoys managing obstipation. There are alcoholic physicians (in remission) who are tremendously effective with alcoholics.

Most physicians have medical hobbies, and many have developed a real talent for handling certain difficult disorders. The problem seems to be that these special interests are not written down anywhere, and the information spreads by word of mouth. This is fairly inefficient, however, so it seems to take a decade or two to learn which pediatrician likes to see obese kids, and which dermatologist enjoys managing atopy.

## HIGUCHI INSURANCE AGENCY, INC.

(808) 531-7091

### HONOLULU COUNTY MEDICAL SOCIETY'S INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE

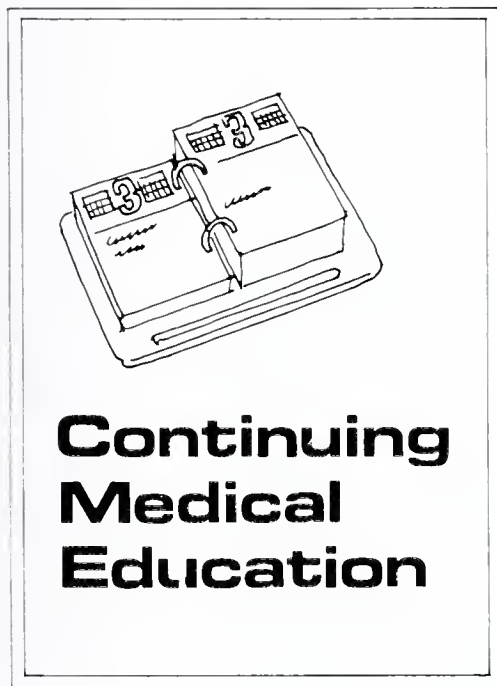
DISABILITY INCOME INSURANCE

DEFENDANTS REIMBURSEMENT INSURANCE



It would be nice if there were a listing somewhere of medical hobbies or special interests, perhaps as a supplement to the HMA directory. This might help us provide a real service to our patients with chronic, difficult disorders, wherein treatment is unrewarding. My friend is looking for a local "insomnia specialist," and I need someone who wants to counsel patients who get "these shooting pains behind the left eye . . ."

J.M.C.



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1½ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.

9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.

##### Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

##### Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

##### Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1. (Contact CME Dept.-Kaiser for further information)

##### Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

##### Kuakini Medical Center

1. Guest Speaker, 4th Mon. 1:00-2:00 p.m.
2. G.I. Conference, 3rd Tuesday, 8:00-9:00 a.m.
3. Nephrology Conference, 4th Wednesday, 8:00-9:00 a.m.
4. Oncology Conference, every Thursday, 7:30-8:30 a.m.
5. Surgical Conference, 1st, 2nd and 3rd Fridays, 1:00-2:00 p.m.
6. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 12:45-1:45 p.m.
7. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, 1:00-2:00 p.m.
8. Ophthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
9. Surgical Conf.-CPC, 5th Friday, 12:45-1:45 p.m.

##### Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd.—Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., 3rd Mon., 7-8:00 a.m.
4. Family Practice Section—3rd Wed. 7-8:00 a.m.
5. Diagnostic Radiology—4th Tues., 12-1:00 p.m.

### The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium  
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium  
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium  
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

### St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Hematology Conf., 3rd Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
7. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

### Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

### Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

### Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: 1, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

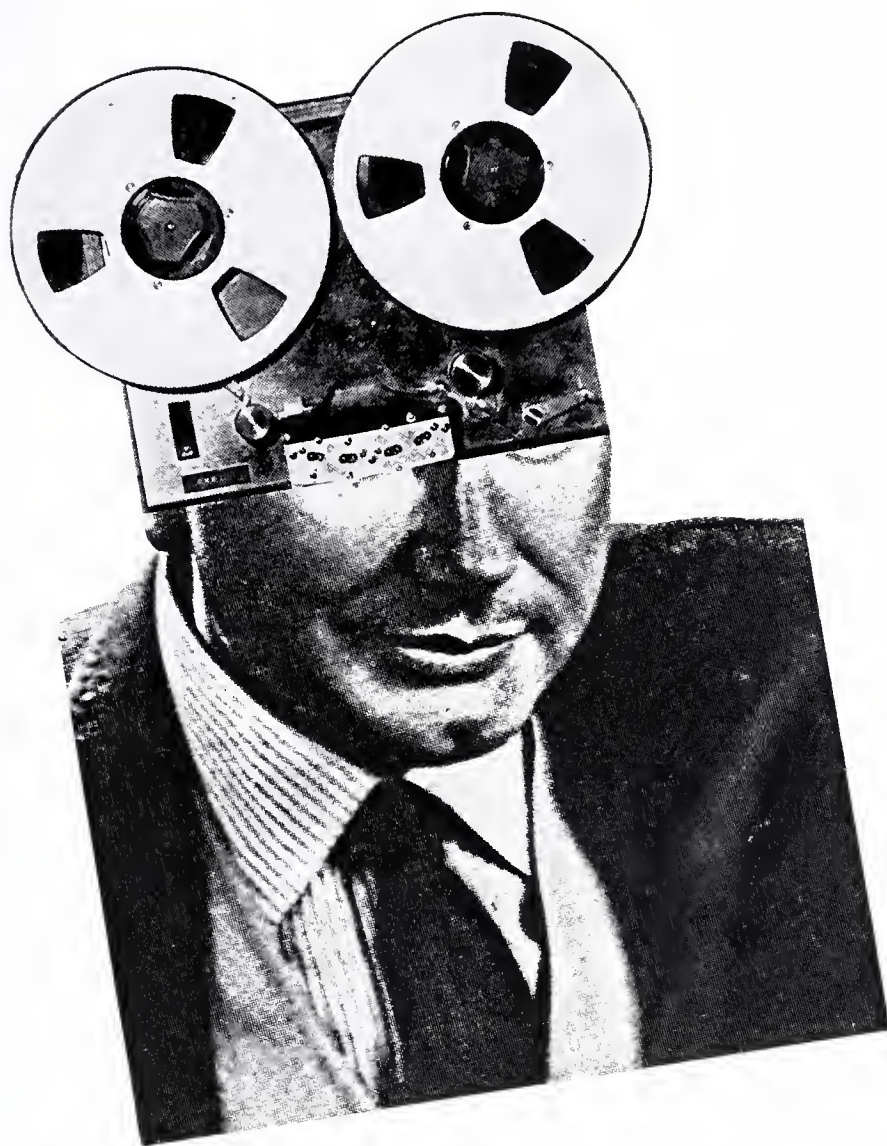
### SPECIAL EVENTS

- Apr.  
May 18,  
1979 Orthopedic Review, USC Sch of Med, Div of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- June 3-  
9, 1979 Diving Med. U of H Schl of Med. 1960 E-W Rd., Honolulu 96822. Held at King Kamehameha, Kailua-Kona, HI. 6 days. Cat. I—25 hrs. Contact: CCECS, UH, 2530 Dole St., Honolulu 96822.
- June 9-  
16, 1979 Radiology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Htl, Kamuela. 5 days, 30 hrs.
- June 14-  
20, 1979 "Patient Learning Through Effective Use of Media"—1979 Phys. Seminar on Patient Ed.-20 hrs. Cat. I CME. Co-sponsor HMA. To be held at the Kulima Hyatt Resort Htl. Contact: Media Institute, S 607 1833 Kalakaua Ave., Hono. 96815 or (808) 955-5908.
- June 18-  
22, 1979 Comparative Psychotherapies, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina Htl, Maui. 5 days, 30 hrs.
- June 23-  
30, 1979 Manipulative Med. USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Sheraton-Waikiki, Honolulu. 5 days, 30 hrs.
- June 29,  
1979 HI Thoracic Soc. (Am. Lung Assoc.) "Management of COPD," 1-2:00 p.m. Waianae Comprehensive Hlth. Cntr. 1 hr. Cat. I. Speaker: Geo. Druger, M.D. Contact: R. Respicio (808) 537-5966.
- Aug. 4-  
11, 1979 Ophthalmology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
- Aug. 8-  
22, 1979 22nd Annual Postgrad Refresher Course, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Cosponsor: U of HI. Held: Honolulu, Maui & Kona. 39 hrs.
- Sept. 9-  
17, 1979 Practical Management of Anesthetic Problems, USC Sch of Med., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 31¼ hrs.
- Oct. 8,  
1979 HI Thoracic Society—Annual Mtg. 7:00 p.m. Fireside Chat, 7:30 p.m. 2 hrs. CME Cat. I—Ilikai Htl. Honolulu. Contact: R. Respicio (808) 537-5966 for further info.
- Oct. 8,  
12, 1979 123rd Annual Convention-HMA/AMA Regional Mtg. Ilikai Htl. Honolulu. 5 days. Contact: HMA Office (808) 536-7702.



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**Friday, March 2, 1979**

**5:30 p.m.**

**HMA CONFERENCE ROOM**

**PRESENT:**

Drs. Goto, Bell, Winn, Hindle, Hanlon, Chinn, Iaconetti, Chang, Azman, Miles, Bruce, Cahill, Howard, Lafferty, Roth, Clingan, Fu, Magoun, Dang, Sia,

and Simmons. HMA Staff present were: Mr. Won, Mr. Saranchock, Mr. Ajifu, Mr. Ontai, Mrs. Kendro, Mrs. Young, and Mrs. Wong.

**CALL TO ORDER:**

The meeting was called to order by President Goto, at 5:50 p.m.

**MINUTES:**

The minutes of the previous meeting were approved with corrections.

**TREASURER:**

The January 1979 financial statement was reviewed in detail and approved subject to audit.

**REPORTS OF COMMITTEES  
AND COMMISSIONS:**

*A. Bureau of Research and Planning:* Dr. Calvin Sia reported that the Bureau has explored the possibility of applying for a subcontract with the Department of Health under the DHEW Center for Disease Control's Request for Proposal for a Community Diabetes Control Demonstration Project. The current proposal is for a 12-month period. The initial planning phase would involve assessment of factors such as statistics available regarding diabetes mortality and morbidity; care resources existent in the State; and educational programs available for professionals who care for diabetics, diabetics themselves and their families, and for public education about diabetes. It was noted that the second phase would be funded separately and would focus on evaluation and implementation of the plan developed in the first phase. The possible subcontract has also been discussed with Mr. George Yuen, director of Health, who is favorable to a subcontract with the HMA. Dr. Sia recommended that HMA actively pursue the submission of a grant proposal as the deadline for submission is March 16.

**ACTION:**

**It was moved, seconded, and passed that HMA pursue the submission of a one-year grant proposal for a Community Diabetes Control Demonstration Project.**

Dr. Sia reported that the Bureau is also exploring the development of HMOs in the state, particularly IPAs (Independent Practice Association), and is considering the direction HMA should take in this area.

*B. Health Service and Care*

*1. Community Health Care:* Mrs. Becky Kendro reported that the Community Health Care Committee will meet in the near future to formulate testimony on the Draft State Health Plan for presentation at upcoming public hearings. The hearings will be held on March 19-21 on Oahu and on the neighbor islands.

The Council was informed that names are being accepted for nominations to the Statewide Health Coordinating Council and Subarea Councils. The HMA plans to submit a slate of nominations to the Governor for his consideration.

*2. Health Manpower:* Mrs. Kendro mentioned that the Health Manpower Committee recently held its first meeting and has outlined its objectives for the year.

*C. Legislation:* Dr. E. Lee Simmons reported that an attorney representing a clinical psychologist has asked the HMA and the Psychiatric Society to enjoin in a lawsuit to challenge the constitutionality of adminis-



trative search and seizure. A recommendation was made that HMA's legal counsel be consulted regarding the appropriateness of HMA involvement in this matter. It was also recommended that AMA be contacted regarding possible interest in the case.

**ACTION:**

**It was moved, seconded, and passed that HMA confer with Mr. V. Thomas Rice and with the AMA.**

Dr. Simmons reviewed the status of legislation pertaining to optometry, Medicaid, chiropractor reimbursement under prepaid health care program, generic drugs, minors' rights to family planning services, HAPI Corpus, and controls on the use of electroshock therapy and psychotropic drugs.

It was also reported that the Senate Human Resources Committee's hearing on S.B. 1609, Relating to Workers Compensation, was canceled. Senator Toyofuku has agreed, however, to submit a resolution calling for a joint interim study on Workers Compensation by the HMA, Department of Labor, and the insurance industry.

Neighbor island physicians were encouraged to contact their legislators to support the passage of the bill which would amend the definition of death law, by removing the requirement for the presence of a neurosurgeon or neurologist to determine brain death.

Dr. Simmons recommended that the Legislative Committee take the issue of chiropractor reimbursement from prepaid health care programs under study. It was suggested that HMA submit more positive legislation such as relating to incentives for patients for preventive health care. The Council agreed that both issues should be taken under consideration by the Legislative Committee.

The Council also discussed the feasibility of having a full-time or part-time lobbyist to assist in the legislative area. The Council requested that this matter be explored further.

Mrs. Becky Kendro was commended by Dr. Simmons for her efforts in keeping track of the over 500 health-related bills and in coordinating HMA responses to such proposals.

*1. Rubella:* With regard to premarital rubella screening, Dr. Denis Fu reported that a meeting had been held with representatives of the Department of Health to discuss the voluntary rubella program. At this meeting, HMA agreed to support premarital rubella screening—provided that follow-up and immunization of susceptible individuals is conducted by the Department of Health. It was also agreed to include a sunset clause of two to five years in the proposed bill. Concern was expressed that the House bill in its present form does not contain amendments for follow-up and immunization. It was noted, however, that there is a similar Senate bill which has not come out of committee but which may include these provisions.

*2. EMS:* Dr. William Dang reported that EMS has submitted an appropriation bill to request funds for next year for continuation of the program. The bill is currently under study by the Ways and Means Committee. EMS has also introduced a bill to request per diem and transportation funds to enable neighbor island people to receive training on Oahu. There is also a bill in the hopper that would postpone implementation of Act 148. The DOH is reported to be studying the possibility of delaying ambulance fee-for-service until January 1980.

*3. Malpractice Insurance:* Mr. Jon Won reported that malpractice insurance statistics on premiums, losses, etc. have been obtained from Argonaut Insurance Company, with more information forthcoming. A suggestion was made that perhaps the HMA should consider acquiring the services of an actuarial consultant to assist in interpreting such statistics and projections. Mr. Won recommended that the appropriate committee be designated to take these figures under study.

**ACTION:**

**It was moved, seconded, and passed that the statistics received from Argonaut Insurance Company be referred to the Legislative Subcommittee on Malpractice Law and Ad Hoc Self Insurance Committee for study and report to the Council.**

*D. EMS Program:* An announcement was made that the EMS contract with the Department of Health, for July 1, 1978 to June 30, 1979, has been signed. The Council was also informed that the EMS Program has submitted two grant applications—one for training of paramedics, and the other for training of critical care nurses under Title VII. On March 5, April 4, and April 19, EMS representatives will meet with SHPDA review bodies to discuss these grant applications for federal funds.

Dr. Dang reported that the EMS Branch of the Department of Health had requested the program's opinion regarding pronouncement of death via radio or telephone.

**ACTION:**

**It was moved, seconded, and passed that HMA feels it inappropriate to pronounce death by radio or telephone.**

*E. Medical Education:* Dr. Nadine Bruce reported that PEC awards have been processed and will be sent out shortly. Physicians' year-end CME records will also be mailed in the near future.

*F. Building:* The Council approved the building budget for 1979. Efforts are being made to align the building budget cycle with that of the HMA operating budget in order that the building budget be considered at the House of Delegates meeting.

*G. Computer:* Dr. William Hindle reported that the Ad Hoc Computer Committee had met with representatives of consultant firms to review proposals for consultant services in automation. The Committee felt that a consultant firm should be retained (as a joint venture of HMA and BME) to conduct a feasibility study to determine whether HMA is ready to move into the area of automation, to determine whether automation of HMA activities would be cost effective, and to suggest other systems that can be instituted to best accomplish our tasks. The following recommendations were made to the Council:

- (1) That it approve expenditures for automation consultant services of up to \$9,000.
- (2) That it approve the retaining of Arthur Young & Company for the initial, definition requirements and plan development phase, not to exceed \$5,200.

**ACTION:**

**It was moved, seconded, and passed that the above recommendations be approved.**

## **REPORTS OF COUNTY SOCIETY PRESIDENTS:**

*A. Hawaii:* Dr. A. Scott Miles reported that Hawaii County has amended its bylaws whereby the Soci-

ety has quarterly membership meetings. The Society will also be offering its members opportunities to obtain CME credits. Hawaii County will continue its membership recruitment efforts. Dr. Miles noted that there has been quite an influx of doctors in the Kona area, but these physicians find it difficult to attend membership meetings in Hilo. Therefore, the Society may consider the possibility of forming another county society or subdividing the present Society into two divisions. This matter will be studied by Hawaii County, and Dr. Miles will report to the Council at a later date.

*B. Honolulu:* Dr. Walter Chang reported that Honolulu County held its first quarter membership meeting in conjunction with the Board of Medical Examiners' public hearing on Informed Consent. At the next meeting on April 9, the Society will have Dr. Beverley Mead as its guest speaker.

*C. Maui:* Dr. Ben Azman reported that Maui County held its second meeting on February 20, and an update on HMA activities was presented by Dr. George Goto and Mr. Jon Won. The Society will have Mayor Elmer Cravalho as guest speaker at its next meeting. Kauai County also plans to amend its bylaws to provide for partially retired members.

Since a number of Maui county members serve on HMA committees, Dr. Azman asked the Council to clarify HMA's travel policy. It was clarified that expenses are the responsibility of the respective county society—unless the physician is attending a meeting of the Council, is chairing an HMA committee meeting on Oahu, or has been invited for a specific purpose. The Council agreed that the travel policy be reviewed by the Finance Committee.

*D. Kauai:* Dr. Thatcher Magoun reported that Kauai County is continuing its membership recruitment drive on a one-to-one basis.

#### NEW BUSINESS:

*A. Physician Reimbursement:* At one time, the HMA had looked into the matter of reimbursement of participating and non-participating contracts under third party mechanisms. The Council agreed that the ad hoc committee should continue its investigation.

#### ADJOURNMENT:

The meeting adjourned at 8:50 p.m.

**Friday, April 6, 1979**

**5:30 p.m.**

#### HMA CONFERENCE ROOM

#### PRESENT:

Drs. Goto, Bell, Winn, Hanlon, Chinn, Iaconetti, Chang, Azman, Miles, Bruce, Fong, Cahill, Roth, Clingan, Fu, Wigle, Mills, Kuboyama, Char, Dang, Sia, Catts, Simmons, Will, Keenan, Hall, Mrs. B. Yim, and Mr. V. Thomas Rice. HMA Staff present were: Mr. Won, Mr. Saranchock, Mr. Leineweber, Mrs. Kendro, Mrs. Chang, Mr. Ontai, Mrs. Young, and Mrs. Wong.

#### CALL TO ORDER:

The meeting was called to order by President Goto at 5:40 p.m.

Dr. Goto asked members of the Council to observe a moment of silence for the passing of Dr. Felix Lafferty.

#### MINUTES:

The minutes of the previous meeting were approved with corrections.

#### REPORT OF THE SECRETARY:

The Council reviewed the status of its membership and noted that there has been a drop in membership as compared to the same time last year. A list of members with delinquent dues accounts was also presented.

Mrs. Ceci Young reported that an article about HMA was recently published in the Agonist (John A. Burns School of Medicine newspaper). In addition, the HCMS Membership Recruitment Committee has set up two liaison persons (medical students) who will meet regularly with the committee.

#### REPORT OF THE TREASURER:

The February 1979 financial statement was reviewed in detail and approved subject to audit.

#### REPORTS OF COMMITTEES AND COMMISSIONS:

*A. Cancer Control Council:* Dr. Thomas Hall, Director of the Community Cancer Program of Hawaii, met with the Council to discuss his 2/28/79 letter to Dr. George Goto. Dr. Hall reported that the Cancer Control Council has decided there should be room on its Executive Committee for specific representatives from interested organizations. The Cancer Control Council therefore requested that its Rules be modified to include additional representatives from concerned organizations such as the ACS, HAH, HNA, DOH, etc. Dr. Hall felt it appropriate to bring this matter to the attention of the HMA Council in case the HMA should wish to nominate a representative to the Executive Committee of the Cancer Control Council. HMA



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Paul S. Isenberg, Ph.D.  
Director  
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686



Cancer Committee Chairman, Dr. John Keenan, recommended that the HMA should be represented on the Executive Committee of the Cancer Control Council since the CCPH is a community program.

**ACTION:**

**It was moved, seconded, and passed that the HMA honor Dr. Hall's request for (nomination for) official representation on the Executive Committee of the Cancer Control Council.**

*B. Request from Community Cancer Program of Hawaii:* Dr. Hall suggested the possibility of a CCPH subcontract with the HMA in an effort to fulfill some of the unmet needs of the community. HMA involvement was suggested in the areas of technical training, technical information dissemination, prevention and detection activities, and multidisciplinary management and follow-up care. The Council also discussed with Dr. Hall the relationship of the Community Cancer Program of Hawaii and Cancer Control Council with the Cancer Center of Hawaii.

**ACTION:**

**It was moved, seconded, and passed that the matter of a possible CCPH subcontract with HMA be referred to the Cancer Committee for more specific recommendations.**

*C. Cancer Commission:* Dr. Drake Will, on behalf of the Cancer Commission, recommended that the Hawaii Tumor Registry be moved to quarters that are reserved for it in the Cancer Center building after negotiation by the HMA for satisfactory agreement that respects the HTR as a separate entity which belongs to the HMA, and that sets up the administrative guidelines that determines what kind of interference the HTR would accept from the people who are in the Cancer Center building.

**ACTION:**

**It was moved, seconded, and passed to reaffirm HMA's position to keep the Hawaii Tumor Registry at its present location at 320 Ward Avenue.**

*D. School Health:* Dr. Roy Kuboyama presented a pamphlet prepared by the HMA School Health Committee and the DOH School Health Services Branch. It was reported that the Committee hopes to prepare periodic information for dissemination to physicians to facilitate school-to-physician communications by clarifying school health policies and procedures. It was noted that the Department of Health would be responsible for printing the pamphlet.

**ACTION:**

**It was moved, seconded, and passed that the HMA accept the school health pamphlet. There were three opposing votes.**

**It was moved, seconded, and passed that the school health pamphlet be disseminated to the membership.**

*E. Sports Medicine:* It was announced that the annual HMA Sports Medicine Symposium will be held on May 4, 1979.

*F. Community Health Care:* Dr. Douglas Bell reported that HMA's reactions to the Draft Hawaii State Health Plan were presented at a SHPDA public hearing on March 21, 1979. It was mentioned that most of HMA's recommendations were accepted by the Statewide Health Coordinating Council on April 5.

*G. Legislation:* Dr. E. Lee Simmons briefed the Council on bills that are still under consideration by the State Legislature. It was reported that the generic

drug substitution bills will be sent to a conference committee due to differing versions.

An amended version of the Administration's Medicaid bill was reported out of the Senate Human Resources Committee. The bill would require the Legislature to determine the level at which physicians would be reimbursed, but the DSSH must project the amount of funds it will require to reimburse physicians at the full 75th percentile allowed by Federal law.

Dr. Simmons summarized that recent amendments have considerably improved the bill to make it quite clear that UCR fees and the most recent profile available at the time of budget-making would be the basis for reimbursement.

Dr. Simmons also mentioned that the rubella bill was reported out of the House Health Committee.

In addition, the Council discussed the request received from an attorney representing a clinical psychologist to join in a lawsuit to challenge the constitutionality of administrative search and seizure. The Council was in agreement with Mr. V. Thomas Rice's opinion that HMA not join in the suit at this time.

*H. Emergency Medical Services:* Dr. William Dang reported that the EMS appropriation bill for the next fiscal year has already passed through the legislative committees on Health, Finance, and Ways and Means.

Dr. Dang noted that ambulance personnel have been experiencing problems in taking patients to various hospitals due to a shortage of critical care beds. The EMS Program has met with the HAH and expects to meet with hospital chiefs of staff to discuss the situation with a view toward bringing this matter to the attention of SHPDA.



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*I. National Health Insurance:* Dr. George Mills, AMA Trustee, recommended that HMA prepare a position statement on national health insurance; and he presented a draft statement (modeled after AMA's statement) for consideration. The Council agreed to refer the draft to the Legislative Committee for review.

Dr. Mills also recommended that HMA respond to a request from Senator Spark Matsunaga for HMA reactions to S. 350 and S. 351 which relate to catastrophic health insurance. If HMA's comments are submitted by the deadline of April 11, they will be incorporated in the congressional records.

**ACTION:**

**It was moved, seconded, and passed that the Executive Committee meet with Dr. George Mills and Dr. E. Lee Simmons to prepare a response to Senator Matsunaga's request.**

*J. Official Family Briefing:* Since the AMA Board of Trustees' is offering an "Official Family Briefing" Program for 1979, the Council felt that HMA should invite the Trustee visitation program to come to Hawaii.

*K. Fee Survey:* On behalf of Dr. Maurice Nicholson, Mrs. Becky Kendro reported that the Fee Survey Committee proposes to print the Procedural Terminology Manual consisting of procedure code numbers and descriptions—no relative (unit) values.

**ACTION:**

**It was moved, seconded, and passed that the Fee Survey Committee recommend to the House of Delegates that HMA publish the Procedural Terminology Manual (in the format suggested above).**

*L. Malpractice Insurance:* Mr. Jon Won reported that HMA is exploring the possibility of some type of dividend program with Argonaut Insurance Company and the State Insurance Commissioner. The Ad Hoc Committee on Self Insurance will further study this matter.

*M. Bureau of Research and Planning:* The Council was informed by Mr. Won that the HMA has submitted, on behalf of the DOH, a grant proposal to the Center for Disease Control (Atlanta, Georgia) to establish a Community Diabetes Control Demonstration Project in Hawaii, with Dr. John Kim as Project Director.

*N. Medical Education:* Dr. Nadine Bruce reported that Kona Hospital was surveyed last month. The Committee will submit its recommendation for accreditation to the LCCME upon receipt of the survey fee. It was also mentioned that A. H. Robins has donated \$200 to HMA for professional education purposes, and the Committee will formulate recommendations on how the funds will be used.

*O. Internal Affairs:* Dr. Neal Winn reported that the Golf Committee has decided to restrict participation in the Annual Golf Tournament to HMA members and their non-physician guests.

## REPORTS OF COUNTY SOCIETY PRESIDENTS:

*A. Honolulu:* Mr. Won reported that Honolulu County will hold its next general membership meeting on April 9, 1979, at the Kahala Hilton Hotel, with Dr. Beverly Mead as guest speaker.

Mr. Won also reported that at the March 20 Board of Governors meeting, a recommendation was adopted to establish an intermediate dues category for

deserving members who do not qualify for full dues waiver or who may have financial hardship at some time (for example, in moving from group to private practice). Honolulu County will reduce its dues in such cases by 50%, and it was recommended that HMA consider a similar reduction of dues.

The Council felt that HMA should not establish an intermediate dues category since there are provisions already existing in the bylaws to allow for full waiver of county, state, and AMA dues of deserving members.

*B. Maui:* Maui County President Dr. Ben Azman reported that the Society held its last Board of Governors meeting on March 20. The Board at this time endorsed the concept of a cancer subcouncil on Maui. Following the Board meeting, the Society held its membership meeting with Mayor Elmer Cravalho as the guest speaker. The next meeting is scheduled for April 17. Dr. Azman noted that the Society is continuing with its membership drive, and a few non-members are invited to each of their meetings.

*C. Hawaii:* Hawaii County President Dr. A. Scott Miles reported that the Society plans to hold its first quarterly meeting in May. On the program will be one of the AMA audio-visual programs for 3 CME credits. The Society is also thinking of instituting a monthly newsletter to promote better communication among its members on the island.

## MISCELLANEOUS BUSINESS:

*A. Auxiliary:* On behalf of Auxiliary President Mrs. Berna Yim, Mr. Won reported that the pilot program for the Auxiliary's part-time office secretary has worked very well. The Auxiliary requested an increase of \$2 per dues-paying member for 1979 so that it will not have to utilize funds from its savings account to continue to have such secretarial services. Approval of the budget request was recommended in view of the Auxiliary's excellent support of physician activities.

**ACTION:**

**It was moved, seconded, and passed that the Auxiliary be allowed an increase of \$2 per dues-paying member for 1979.**

It was noted that the Auxiliary should submit another budget request to the House of Delegates in October.

*B. Building:* Mr. Won reported that there was a break-in of the HMA office on the weekend of March 24-25. Losses amounted to approximately \$265 in cash. A police report has been filed, and an insurance claim has been filed for damages to the equipment. HMA staff is currently looking into costs for some kind of burglar alarm system.

*C. AMA Meeting:* Mr. Won informed the Council that the AMA Board of Trustees would be very happy to receive an official invitation from HMA proposing Hawaii as the site for an AMA (winter) meeting in 1984 or beyond.

**ACTION:**

**It was moved, seconded, and passed that a letter of invitation be written to AMA.**

Dr. Chinn, AMA delegate, requested that the membership be invited to attend the AMA Interim House of Delegates Meeting which will be held December 2-5, 1979.

## ADJOURNMENT:

The meeting adjourned at 10:45 p.m.





## Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

# A Special Decade 1969-1979

Due in large part to the Academy's efforts, family practice became medicine's 20th primary specialty on February 8, 1969.

Great strides have been made in 10 years!

- More than 19,000 family physicians have been certified by the American Board of Family Practice.
- Currently, there are 362 accredited family practice residency programs.
- This year, 6,033 family practice residents are in training. Since 1970, approximately 5,000 young men and women have completed their residency training.
- In 10 years, Academy membership has grown from approximately 31,000 to more than 44,000!
- Academy members—many serving by example and supporting AAFP programs and others by becoming full-time teachers—are improving future Americans' chances of having enough family physicians in the communities where they are needed.
- Building on its tradition of innovative continuing medical education programs, the Academy recently introduced the convenient Home Study Self Assessment Program.

**New Members**—None this time.

**Members Lost**—By sudden and shocking demise: **Felix Lafferty** on 4 April in his prime. The Hawaii Chapter Council has established the Felix Lafferty Student Memorial Fund to encourage medical student participation in Chapter activities; Felix' dedication to the teaching of students and residents was known to all in the profession. Dropped from membership for one reason or another: student members **Kevin Kunz**, **Curtis W.Q. Lee**, **Kenneth T. Nakamura**, **Richard A. Pekala**, all of the UHSM class of 1979, and **Annie Marie M. Santos** of the class of 1981.

**News of Members**—our honored member **H.Q. Pang** has been granted Life membership. Immediate

Past President **Tom Cahill** had a letter-to-the-editor (Star-Bulletin 2 May) lambasting the State Health Planning & Development Agency for restricting the evolution of the practice of medicine and denying people benefits all in the name of "cost control." This is actually directed at PL 93-641 imposed upon us by the U.S. Congress. The Council recommended to SHPDA that **Don Farrell's** third year of the UH-Kaiser Family Practice Residency Program application for federal funding be approved.

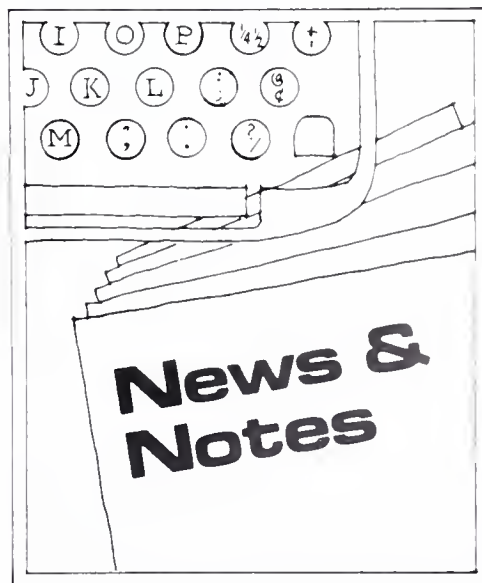
**A Special Decade**—The AAFP's logo for the year draws attention to the tenth year birthday of the American Board of Family Practice which will be celebrated at the annual meeting in Atlanta, Georgia, 8 to 11 October.

**CMER**—ExecSec Roger Tusken replied in a 3-page letter to our gripes about the Computerized Medical Education Record which we know as the "Computer's Printout." The computer is only as accurate as the input; input is by people and not via thoughtwaves. One of the major problems is that the Computer does not recognize anything except the *exact and specific* title of an approved course or credit hour. If the member fudges the title on his yellow or green card, the Computer records it as "Non-designated." Catch on?

**CME**—There's lots coming up! Don't forget the big one: UH-USC-TAMC in August 11 to 22 at the Waikiki Sheraton and then Maui or Kauai. Core Content Review is bigger and better; register by 31 August for 32 hours of "P" for \$60. The Georgia Academy offers: Primary Care Update—Home Study Course for 125 hours "P" starting 10 Sept 79 with enrollment deadline 4 June for \$475, plus a Newborn Course and a Geriatrics Course starting in October with July deadlines for \$275 each.

**Hawaii Review**—is the title given, accompanied by a neat Hawaiian Petroglyph logo, by the BC Chapter, Canadian College of Family Physicians, in a brochure that credits the HAFP with "presenting" the program 1-4 February 1980 at the Hilton Hawaiian Village. This will be in conjunction with our annual meeting. **Dave Swanson** is very busy organizing the details of this Hawaii/British Columbia joint meeting here.

**Next Dinner Meeting**—end of June; watch for the notice in your mail.



HENRY N. YOKOYAMA, M.D.

## Letters To The Editor:

Dear Henry:

With reference to your "Life in these Parts" HMJ 1/79,

page 26 quoting Kauai District Health Officer Robert Melton on cases of Leptospirosis in 1978 . . .

Two of my farmer sons, Paul and John, successively contracted Leptospirosis in 1978 while working their taro lo'i in Waiahole Valley. Both developed meningitis and recovered. (Now don't say that explains their fanatic resolve to keep on grubbing *a la* ancient Hawaiians in the dirt, while their contemporaries only play music!) Both had wounds on their legs that were not fully healed before they returned to the mud. Local kids love to play in the streams that feed their auwai, but don't seem to come down with the disease. The DOH *still* has not conducted an investigation as to the source of the contamination, or at least they have not told me about it.

Taro-farming has become a hazardous occupation—not only in terms of the spirochetal enemy, but also in the fight against the Honolulu Board of Water Supply which has screwed the farmers out of their water in order to allow people in hi-rises to get theirs.

Aloha,

J. I. Frederick Reppun MD

## Life In These Parts

Bob Krauss, our favorite *Advertiser* columnist, tells in his inimitable style about an intolerable situation of bureaucratic interference existing here and elsewhere. "2 Beds—A Tale of Red Tape:" "The Ann Pearl Intermediate Care Facility on Waikalua Road hereby receives a Krauss Citation for the Preservation of Sanity in the Face of Bureaucratic Red Tape. Maybe the citation should be called the Double Bed Award. Two weeks ago the Ann Pearl people applied for a certificate of need to add two more beds to their care center, thereby rousing the monster machine called Chain of Command . . . The application went to the State Health Planning and Development Agency (SHPDA) which ran a public notice in the *Advertiser* to announce that the two beds will be under consideration by five appropriate councils, agencies and committees. First they went before the Windward Oahu Subarea Health Planning Council Tuesday in the Windward Comprehensive Health Center . . . The WOSHPC will then carefully consider the two beds from all sides on April 12 at 5 pm in the Castle Memorial Hospital board room and will make its finding and recommendation to the Hawaii Statewide Health Coordinating Council Certificate of Need Review Panel . . . Next, the HSHCCofNRP will meet to review the application for two more beds on May 8 at 9 am in the Lehua Room of the Hawaii Institute for Management and Analysis in Government, more commonly known as HIFMAAIG . . . Having duly deliberated over the two beds, the HSHCCofNRP in the HIFMAAIG will make its finding and recommendation to the Hawaii Statewide Health Coordinating Council . . . However, HSHCC has a problem. They plan to meet on May 17 at 4:30 pm, but the public notice said they haven't decided where. Unless they come to a decision, Ann Pearl's two beds may be in trouble . . . If we can get over this hurdle, the HSHCC will make its finding and recommendation to the State Health Planning and Development Agency (better known as SHPDA) which received the application in the first place . . . Anybody who wants to testify about these two beds is invited to call 548-4050 . . . The public notice also described the procedure for Queen's Medical Center to expend \$877,314 to replace existing cardiac catheterization equipment . . . I'd tell you about it, but you'd just break down and cry . . ." (Ed: And so would so many others from medical groups and hospitals . . .)

### Thumb sucking . . .

Pediatrician **Dr John Peyton** remembers one woman who tried to keep her son away from his thumb by making him wear boxing gloves all day . . . This did little to deter the young fellow who then got in all his sucking at night after she removed the gloves for his bath and bedtime." (From parents' survival kit By Lynne Friedlander and Denby Fawcett)

### Secession? . . .

From Dave Donnelly's Hawaii: "How about a Statehood

Recognition Award for the Audio-Digest Foundation of Glendale, Calif, which sent **Dr John Corboy** a letter with 62 cents postage and a note which said, 'We realize that the postage on the enclosed postcard is not appropriate for your country. Please hold this card until your arrival in this country.' Corboy wrote back, in part, 'Inflation and postal unions notwithstanding, my country is only \$0.15 away from your country. At least until secession.'"

### Like winds . . .

From Daacon's column: "After meeting with presidential contender Phil Crane, the other day, **Dr E. Gordon Dickie** pronounced him 'the sharpest guy I've ever met.' Of course they had instant rapport—Crane's against socialized medicine too."

### Sexy knees . . .

"**Dr Erida Reichert**, (she's the State Dept. of Health leprosy program head) sat on the sidewalk near leprosy patients evacuated from their Trotter Building quarters at Leahi Hospital during the fire there, smoking a cigarette and looking around at the casual garb worn by **Dr Verne Waite** and Leahi administrator Abraham Choy, who had rushed from their nearby homes to see what they could do to help. Both were wearing shorts. 'This,' Erida said between drags on her cigarette, 'is the first time I've seen these boys' knees. They're loooking good.'" (Daacon item)

### Exotic tatoos . . .

"Local dermatologist **Dr Norman Goldstein** is world touring his amazing 'World of Tattoos' exhibit which includes exotic and erotic tatoos, rare and unusual tattoo instruments, Samoan tattoo equipment, and a 700-year-old Hawaiian tattoo needle from the Bishop Museum . . ." (Another Daacon item)

### Medicaid frauds . . .

The firm of Arthur Young and Company which was contracted to study the handling of Medicaid claims reported that the State's handling of Medicaid fraud and abuse cases is inadequate and haphazard. Part of the problem is that the DSSH has no organized system to follow up potential fraud cases . . . The firm recommends that the DSSH set up clear guidelines for the handling of cases and quickly send on possible fraud cases to the attorney general's unit for investigation.

### Debunking myths . . .

At a recent nutrition workshop, **Ralph Hale**, chairman of the OB-Gyn Dept of the UH School of Medicine, zeroed in on the problem of trying to debunk myths perpetuated by athletes pushing vitamin and protein pills. "People who are selling protein supplements try to find someone who looks like what you'd like to look like . . . It's the same Madison Avenue principle they use to sell cars, and it works . . . The problem is that athletes are one of the most faddish individuals around . . . But nothing substitutes for work, training and basic ability . . ."

### The teller of jokes . . .

"Kathy Blackburn swears that Fronk Clinic gynecologist **Dr Arno Mudndt** can keep his patients in stitches whether he's in surgery or not. Arno's one of the great joke-tellers in all of doctordom . . ." (Daacon)

### CPR for housewives . . .

Diane Mehta relates how the Hawaii Kai Fun Runners started their own cardio-pulmonary resuscitation training course for residents. "One morning a year or so ago, my husband, who is a Kaiser Hospital physician in internal medicine, woke up not feeling too well, but shrugged it off and went to the hospital anyway. Once there, he collapsed with a heart attack . . . After it was all over, I realized that if the attack had happened at home, he might not have survived, because I was not equipped to do CPR until help arrived."

### Legal death bill amended . . .

Legislators passed and sent to the governor a bill allowing



any two physicians—regardless of their medical specialty—to determine when ‘legal death’ occurs in a patient being kept alive by artificial life-support systems. The present law requires that a neurologist or neurosurgeon be consulted in making such a medical determination. But such specialists are not always available, especially on the neighbor islands . . .

### *Hawaiian activists . . .*

**Emmett Aluli**, Molokai physician, who has been active in the action against the bombing on Kahoolawe journeyed to Kona to lead the protesting Hawaiians and their supporters evicted from Kona resort lands belonging to the Hilton Head Company of South Carolina. At issue in the dispute is the archaeological effects and Hawaiian artifacts including petroglyphs on the site . . .

### *How to avoid ciguatera poisoning . . .*

**J. K. Sims** who is doing research on fish poisoning gives a bit of practical advice . . . If you suspect the fish you’ve caught is going to give you ciguatera poisoning . . . “You can give a bit of the raw fish to your cat (or a mongoose or a dog) and see what happens. If the cat throws up or becomes unsteady on its feet, don’t eat the fish.”

## Miscellany

Watanabe san went to an eye doctor because he no can see too good. The ophthalmologist carefully examined Watanabe san’s eyes and said, “I’m afraid you have cataracts.” Watanabe san was befuddled, “No! No! Me have Datsun and Toyota, but me no have Cadillacs.” (As told by Jon Won)

If the answer was “crick,” what was the question? The question was “What is the sound made by a Japanese camera.”

If the answer was “Livingstone I Presume?” what was the question? The question was “What is your full name, Dr. Presume?” (As told by Harry Arnold Jr)

## Community News

The five-story Cancer Center of Hawaii was dedicated on March 26. Lawrence Piette, director, described the center as representing four years of planning and construction and a total cost of \$4,650,000. The center received \$2,635,000 from the federal government; \$1 million in addition to the site donated by Queen’s Medical Center, and \$975,000 awarded by the State. Research labs on the 3rd and 5th floors are equipped for cancer immunology, cell biology and the study of environmental carcinogens and the development of therapeutic drugs. Three of the five floors are devoted to specialized laboratories and offices, and the basement houses parking and animal quarters . . . The computer center is used for retrospective studies correlating risk factors for cancers and provides computer analysis for all of the center’s programs . . . Three patient oriented programs are going on at the center using experimental treatments . . .

At the annual March of Dimes Golden Kilometer, on April Fool’s Day, **Sharon Bintliff** had won the first prize for costume. She wore a C & W outfit and carried a shovel and sign designating her as “Aku’s Personal Sanitary Engineer” and during Aku’s speeches, she regularly made use of the shovel . . . But Sharon gave up the medal when **Rodney Boychuk** arrived in an ambulance heralded by sirens wearing a diaper and an oxygen tent.

## Entrepreneurs

“Straub neurologist **Dr Kenneth Nakano** plans a nerve-racking May trip to Japan to promote his new book with the catchy title “Neurology of Musculoskeletal and Rheumatic Disorders” (a Daacon item)

*Pacific Business News* editorial: “The sharp reduction in medical malpractice claims in Hawaii over the past three years is the result of a sensible approach to what was becoming an almost catastrophic problem. The 1976 legislature set up a compensation fund and a medical claims conciliation panel. All medical malpractice claims go before a panel before getting into court. The out-of-court settlements have sharply

reduced cases that get to court. And the panels have found valid malpractice liability in only a little over a third of claims heard. The result has been no increase in malpractice insurance rates and some hope that the rates will be reduced in the future . . .”

**Claude Caver** in a *Honolulu Star Bulletin* story suggested that the State take control of strike bound industries, collecting revenues until a strike is over when management and workers would get paid. “This is a proposal to oversee labor-management disputes by employing a mechanism which does not interfere with existing labor laws and which prevents the severe direct and indirect losses incurred presently.” Claude proposes legislation which would require that whenever negotiations fail, labor and management officials notify the Governor. The Attorney General would service the necessary writs and the state treasurer would assume fiscal control of the industry. The industry would be legally required to continue all normal operations, but all the receipts of the industry would be put into a special industry escrow fund by the treasurer. Pay checks would be cut as usual, but would be held by the treasurer in a special labor escrow fund. negotiations would continue, but no payments would be made to labor or management. “With the industry in a state of ‘business as usual’ the related public services would not be lost, there would be no direct or indirect unemployment, no increase in welfare rolls, no loss of corporate or personal income taxes, no loss of Social Security, profit-sharing, retirement, or health insurance contributions, no equipment deterioration, no crop losses, repossessions, collection suits, foreclosures, or economic depression.” All business would continue as usual as long as the strike lasts, but neither labor nor management would receive any compensation just as they do not now during a strike. When there is a settlement, the officials notify the governor and the treasurer pays the balance of both escrow funds to labor and management in a lump sum. Management gets all its cash flow income; labor gets back all its accrued wages plus its negotiated gains . . .

## In Memoriam

“By every measure, a superb physician” Herein are excerpts from a eulogy for **Felix J Lafferty** written by George Chaplin, Editor in Chief, *Honolulu Advertiser*: “Voltaire said, ‘Men who are occupied in the restoration of health of other men, by the joint exertion of skill and humanity, are above all the great of the earth . . . They even partake of divinity, since to preserve and renew is almost as noble as to create.’ Felix James Lafferty, M.D. was the kind of physician who gave life and truth to Voltaire’s use of superlatives . . . It is said of Hippocrates, the father of rational medicine, that he was ‘calm and effective,’ humane and observant, prompt and cautious, at once learned and willing to learn, eager alike to get and give knowledge, unmoved save by the fear lest his knowledge may fail to benefit others—both the sick and their servants the physicians—incorruptible and pure in mind and body.’ Felix Lafferty was a physician in that tradition. He wore the mantle of Hippocrates. He was a wise counselor who treated people, not just ailments. He practiced that branch of medicine which most people need most of the time. Felix possessed in abundant measure all those qualities which in contemporary medicine people seek in a family physician: He was accessible . . . He measured up to the expectation that he could take care of most of your problems . . . He also had a high skill when a referral was indicated. Being deeply involved in the community, he knew who and where the supportive resources were and he could make a referral to another physician or organization without any sense of inadequacy . . . And finally he was empathetic, warm and caring, with a close rapport with those he treated.

Sharing his view of Felix with me, Fred Gilbert used only eight words, but they spoke volumes. “Felix,” he said, “was by every measure a superb physician.”

Felix had what Albert Schweitzer wrote and spoke about so much—a reverence for life. He was not a religious man in a ritualistic sense, but he was deeply spiritual in terms of how he lived each day, with unstinting love of his neighbor and of all living creatures . . .

How can we ever forget Felix's ready smile, his sparkling eyes, his brisk movement, his gentleness, his goodness, his giving of himself?

It has been said that 'medicine cannot give immortality, but it should enable us all to live out our full lives.' The passage of time alone is not a precise measure of a full life, but the quality and contributions of one's life are perhaps a better yardstick. By that standard, Felix Lafferty lived fully—and since one's good deeds develop a momentum of their own, ramifying out in countless ways, Felix will remain with us in blessed memory."

## Oncology Conference

A 70-year old woman with recurrent Paget's disease of the perineum had the lesion resected and pathologist **Larry McCarthy** showed beautiful slides of the lesion, explaining at length how it occurs in breasts and perineum . . . Moderator **Quint Uy** quipped, "It seems to occur in the erogenous areas of the body. Is it more common in prostitutes?" Larry deferred answering to fellow pathologist **Takushi Hayashi** who in turn deferred to **Grant Stemmerman** who was ecstatic: "It is a most uncommon disease and a disease difficult to live with. Apparently topical treatment with 5 FU can be used as adjunct to surgery." When Quint Uy turned to oncologist **Kevin Loh** for elaboration, Kevin, for the first time to our knowledge, merely commented, "No experience."

## Visiting Physicians

Stevio Julius, Professor of Internal Medicine, U of Michigan, was here in the latter part of March. Herein are a few gems from his lecture on "The Use of Beta Blockers in the Treatment of Hypertension."

re Impotence: "The worst offender is the diuretic." (When Irwin Schatz asked sweetly if this was also true in women, Steve replied, "I'll make my best effort to find out.")

"The best combination is hydralazine with a diuretic and propranolol (up to 320mg)"

re Withdrawal phenomenon: "I'm careful only with patients with angina. The question is whether it is a rebound phenomenon or simply worsening of angina under control by propranolol . . ."

"Propranolol is the first drug that treats coronary heart disease as well as hypertension . . ."

"Europeans use 1 gm to 1½ gm/day . . . I don't feel any justification for such doses . . . I consider 640mg a day as maximum . . ."

## Conference Notes . . .

**Irwin Schatz** on Anticoagulant Therapy at a QMC Friday morning conference:

re Heparin Rx: Activated PTT should be 1½ to 2½ times control, but it is frequently resistant to the initial bolus . . . The problem is how much heparin to give and how . . . The Swedes pick a number like 5 or 6,000 every few hours and do not do any tests . . . If the patient does not bleed, they do not stop . . . Women over 60 have a greater propensity to bleed with heparin therapy . . .

When to Anticoagulate? In cases of cerebral emboli with auricular fib . . . Give heparin after 48 hrs. It's a cardiologists' view or my own view, correct or not . . . (Neurologist **Robert Hinman** presented his own views in a 5 minute dissertation which in essence was contrariwise.)

re Minidose Heparin: Use when there is risk of thromboembolism even with no evidence of thrombophlebitis of the calf . . . The advantage is the safety factor—with all the number of patients getting minidose heparin safely . . .

Value of Minidose Heparin: There is enough evidence in post MI patients that they are being protected . . .

If we rely heavily on any lab test (esp activated PTT), we get into trouble.

## Elected, Appointed & Honored

**Col David Swanson**, chief of Family Practice at Tripler, is the new president of the Hawaii Chapter of the American

Academy of Family Physicians, replaced **Thomas Cahill** of Pearl City. **Patricia Dietrich** was elected president-elect; **James Tsuji** secretary and **Fred Reppun** treasurer. Council members elected were **Don Newman**, **Glenn Stahl** and **Lincoln Luke. H. Q. Pang**, still in active practice, was honored for his 50 years of practice at the Chock Pang Clinic . . . Patricia Dietrich is a diplomate of the American Academy of Family Physicians, having passed the academy's board examinations . . .

**Marion Hanlon**, past president of the HMA, was presented the "Physician of the Year" award by Maui County Medical Society president **Ben Azman** . . .

**Edward Hsia**, professor of genetics and pediatrics at our School of Medicine, received a grant of \$50,813 and **Rodney Boychuk**, a neonatologist at the medical center received \$33,990 from the National Foundation—March of Dimes . . .

**Stanley Saiki** was re-elected secretary of the HMSA and **John Edwards** was newly elected to the HMSA's Board of Directors. Also re-elected as directors were **Sakae Uehara**, **William Spies**, and **Stanley Saiki**.

## Thomas Jefferson Award

We have extracted liberally from Bob Krauss's column re our modest **Charlie Judd**, physician winner of the national Thomas Jefferson Award; "The record for single handed medical service in Honolulu may be held by Dr Charles S. Judd who once saw 27 patients in 2½ hours from an old army trailer in Kalihi . . . A chief in Samoa once insisted on flying all the way to Hawaii so he could consult Judd in the army trailer where the doctor listened sympathetically, gave the chief an aspirin and sent him home . . . Then there was the old Filipino man in Kalihi whom Judd could not help. The old man refused to go to the hospital because there would be nobody at home to feed his dog . . .

Kokua Kalihi Valley is a unique non-profit organization that works toward health and reconciliation (healing wounds, restoring bad feelings) in Kalihi . . ." The following are quotes from Joris Watland, KKV executive director: "We picked up three World War II army trailers and converted them into a clinic. Charlie helped fix them up. He came every Wednesday at 2pm and stayed until all the patients were taken care of. Initially, it was mostly crisis care. I've seen him take one look at a patient and call the ambulance . . . Our older people trust him so much. When he's with a patient, no matter how busy it is around here, it's as if nobody else matters . . . He says it doesn't matter what our facility looks like. The important thing is the quality of care . . . One physician told me Charlie really isn't a doctor. He's a missionary, that he's an eccentric . . . We wish more people were eccentric about concern for their fellow man." (Ed. And we do too!)

## Our "Angels"

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**From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'**

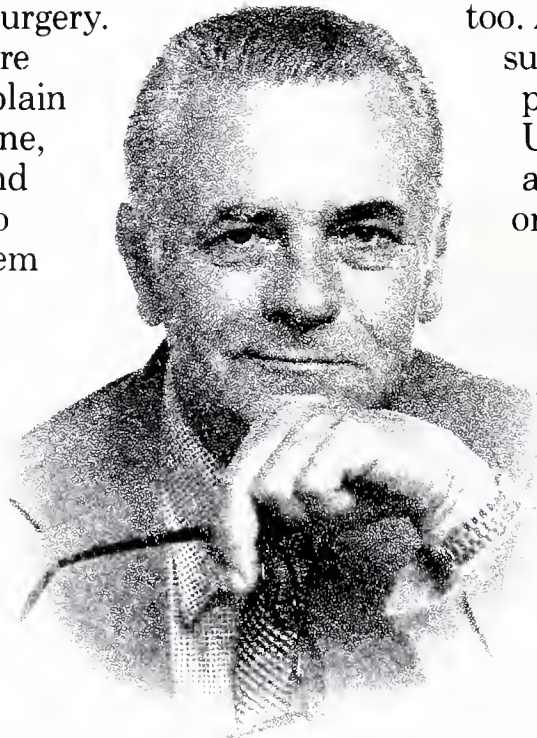
To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk

about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

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# A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# The Maker

## Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



*MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.*

**FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were**

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

*MYTH: Industry favors only "expensive" brand names and denigrates all generics.*

**FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.**



# Matters.

**MYTH:** Generic options almost always exist.

**FACT:** About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

**MYTH:** Generic prescriptions are filled with expensive generics, thus saving consumers large sums of money.

**FACT:** Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

**MYTH:** Drugs account for a major portion of the rise in health care costs.

**FACT:** Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

**MYTH:** Government intrusions into the marketplace will save tax money.

**FACT:** Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

## The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

## The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



Pharmaceutical Manufacturers Association  
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**Contraindication:** Previous hypersensitivity to penicillin.

**Warnings:** Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

**Precautions:** Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting,

gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

(102175)

**\*Equivalent to penicillin V.**

*Additional information available to the profession on request.*



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# A Study of the Cognitive Status of Abused Children Admitted To a Child Psychiatric Ward

CLARENCE E. McDANAL, JR., M.D., and WILLIAM M. BOLMAN, M.D., *Honolulu*

● *The importance of recognizing and treating cognitive disorders in abused children is studied in 36 abused children admitted to an in-patient child psychiatric ward. The abused children were compared with other admitted children regarding intelligence and learning disabilities. The frequency of abuse was approximately twice as great in the mentally retarded (40%) and in children of normal intelligence but with learning disabilities (42%), as compared with children of normal intelligence and with no learning problems (19%).*

It has been observed that many abused children have serious intellectual handicaps.<sup>1,2</sup> In a study of 21 pre-school children from multiproblem, hard-to-reach, disorganized families, Malone concluded that external factors contributed to the rigid literalness and concreteness of their learning and thinking.<sup>3</sup> Martin found 33% of 42 abused children to function at a retarded level.<sup>4</sup> In their follow-up study of 21 abused and neglected children, Morse, Sahler and Friedman found 9 (43%) to be retarded.<sup>5</sup>

We have had an opportunity to treat a number of children who had been abused early in life. We found it difficult to give comprehensive care to these children without paying close attention to their cognitive needs. Because of our interest in learning disabilities, we decided to do a retrospective study of the hospital charts to examine the incidence of learning disabilities and of mental retardation in abused children, compared with the other children hospitalized on the same ward. In this paper, we present the results of that study.

## Method

Medical records of 113 emotionally disturbed children admitted to a 15-bed, in-patient, chil-

dren's psychiatric ward in Hawaii from July, 1972, through July, 1975, were reviewed. Clinical entities evaluated were child abuse, mental retardation, and learning problems. The abused children studied had a history of investigation by a child protective service team or had a history of severe abuse. The reports, tests, and evaluations of child psychiatrists, child psychiatry fellows, psychologists, social workers, school teachers and school counselors were used in assessing clinical findings, academic levels, learning problems, and intelligence. Excluded from the study were two children whose records were incomplete. Another 7 children were placed in a "gray" zone because they did not fit clearly into the abused or nonabused group.

## Results

Of the 104 children studied, 36 (35%) had a history of maltreatment. Of these abused children, 29 were boys and 7 were girls. Their ages ranged from 4 years 1 month to 13 years 11 months.

Of the 36 abused children, 12 (33%) had borderline or lower intelligence. Of these 12, there were 9 boys. The most common mental retardation category was "borderline," with 7 falling into that group. Mild mental retardation was noted in 3, and 2 were in the moderate range. Of the 36 abused children, 24 (67%) had at least normal intelligence but significant learning disabilities. Thus, all of the abused children had learning problems of at least moderate severity.

The other children hospitalized on the psychiatric ward during this period were used as the comparison group. This group consisted of 68 children, ages ranging from 4 years 8 months to 14 years old. There were 56 boys and 12 girls. A total of 18 (26%) were retarded, 25 (37%) had

TABLE 1.—Patient Distribution Regarding Cognition

	RETARDED		NORMAL INTELLIGENCE WITH LEARNING DISABILITIES		NORMAL INTELLIGENCE WITHOUT LEARNING DISABILITIES		TOTAL	
	NO.,	(%)	NO.,	(%)	NO.,	(%)	NO.,	(%)
CONTROL	18	(26)	25	(37)	25	(37)	68	(100)
ABUSED	12	(33)	24	(67)	0	(0)	36	(100)
GRAY	2	(29)	4	(57)	1	(14)	7	(100)
TOTAL	32	(29)	47	(42)	32	(29)	111	(100)

normal intelligence with learning disabilities, and 25 (37%) had normal intelligence without any diagnosed learning problems. Thus, a total of 43 (63%) of the comparison group showed either retardation or learning disabilities.

In the population of normal intelligence without learning disabilities, the rate of abuse was 6 among 31, or 19%. In the population of normal intelligence with learning disabilities, the rate of abuse was 18 among 43, or 42%. With mentally retarded children, the rate of abuse was 12 among 30, or 40%. These figures suggest that youngsters admitted to a childrens' psychiatric ward and who have either mental retardation or learning disabilities have approximately twice the chance of being abused as do children of normal intelligence with no learning disorders. From these data, one would also expect approximately the same rate of abuse among mentally retarded children as among normally intelligent children with learning disabilities.

### Discussion

As In and McDermott pointed out regarding treatment of child abuse, more is necessary than simply removing the child from a dangerous environment.<sup>6</sup> Our data suggest that these children should have evaluations for intelligence and learning disabilities, and should be placed in the proper school environment. Otherwise, with repeated school failures, the child will feel even more inferior, with poor self esteem due to cognitive problems. This can lead to regressive or

aggressive behavior, which could be mistaken for psychosocial problems.

There is an interrelation between ego development and the maturation of intellectual capacities. One of the main functions of the ego is adaptation to reality, which includes mastering new skills. In certain areas as life and death survival, abused children may have well developed egos and appear very precocious. In other areas, such as acquiring language and math skills, there is limited ego development with little flexibility for learning. In his study of homicidal youths whose "family situations were full of turmoil," King found developmental deficits in language abilities. He stated, "Among our youth, a most disabling deficit in their development was, as already indicated, their inability or disinclination to master the prevailing language."<sup>7</sup> Kempe reported in abused children, "Other parameters that remained part of the picture throughout were delays in maturation of speech and verbal expression of feelings. The use of spontaneous language to promote their relationships was rarely seen."<sup>18</sup>

Although there is a disagreement about the incidence of learning disorders in the general population, most investigators do agree that approximately 10% of school children have reading problems.<sup>9,10</sup> Martin stated, "While data from a study of elementary-aged abused children is not yet completely gathered and analyzed, it is clear that abused children are at considerably greater risk of having learning disorders in school than their non-abused peers."<sup>11</sup>

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*Is the present Workmen's Compensation System  
a boon or a hindrance to workers getting well?*

# The Injured Worker—Dimensions of Trauma

JOHN C. MEBANE, M.D., F.A.P.A., *Hilo*

● *Primary prevention in mental health, if one excludes entities such as genetic diseases or infections, revolves about complex psycho-socio-cultural educational approaches.<sup>1</sup> Accidents and other physical traumas may result from a specific event and are often a precipitation of major physical and mental health problems.*

Despite numerous complexities, the question of primary prevention of mental health problems in the injured worker seems to offer some promise. One would expect workers generally to be relatively stable and responsive to a preventive program; the work setting provides a structure within which such measures could be implemented, and the State of Hawaii Department of Labor monitors in detail numerous aspects of work injuries, causes and costs.<sup>2</sup>

Study of the injured worker in the Hawaii County locale may reveal valuable preventive insights. Here the incidence of deaths for all accidents—industrial and otherwise—in 1976<sup>3</sup> ranked highest of the State's 4 counties: 56.1 per 100,000 total resident population, compared with the State average of 30. Hawaii County, with 8.5% of the State's work force in 1976, reported 12.5% of the on-the-job injuries. This disproportion also held true in the counties of Maui and Kauai. Honolulu County, with 80% of the work force, contributed 71.5% of the injuries.

Workers who are injured on the job present special management problems for their physicians. Emotional undercurrents, not uncommon in injuries generally, become very strong for the worker who sees himself threatened with incapacity while serving some larger body—a work organization which each worker perceives in his own special way. With injury, the work-oriented person finds a primary source of his emotional support in jeopardy, and may display a spectrum of reactions from apathy and depression,

through anger and projection of guilt or blame, to chronic invalidism.

The work situation in some ways is not greatly different from a military operation or a professional athletic season; however, work is a daily activity routinely close to most of us. We may fail to see the human drama which might otherwise warrant the front page or at least a sports section news headline. This may be one reason why the Committee on Psychiatry in Industry (Group for the Advancement of Psychiatry) recently reported a great lack of coordination and integration of efforts of those involved in treating the injured worker.<sup>4</sup>

This committee found major and growing needs for direction, in order to integrate and coordinate the efforts of those involved, and to utilize fully the knowledge available from the behavioral science field. The committee concluded, "Those involved in the compensation process cannot continue to ignore the importance of the psychosocial environment of the worker."

The present study is a preliminary attempt to assess one community's experience and degree of coordination of efforts in the comprehensive treatment of the injured worker—an assessment by a psychiatric consultant focusing on aspects of the worker's clinical problems and psychosocial environment, as obtained via a traditional referral and evaluation process.

## Subjects and Method

A total of 45 work-injured patients were seen for evaluation during the period 1973 through 1978. Their injuries occurred between 1969 and 1978. Reported industrial accidents in the state over the past 10 years have annually averaged 35,000, of which Hawaii County's share approaches 4,375. This means that this small study sample was drawn from a total of some 39,375 reported injuries in this community.

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Psychiatric interview and mental status evaluation techniques were used during direct contact of 2 or more hours on separate occasions. In addition, approximately half of the subjects completed the Minnesota Multiphasic Personality Inventory (MMPI).

Hilo is the urban county seat of a primarily agricultural island community whose population approaches 80,000. The close-knit community setting provides the physician with rich extra-clinical observational data to sharpen assessments. The author did not, however, function in any formal or structured capacity with company medical departments, insurance companies, the Department of Labor and Industrial Relations, unions, or other agencies.

Demographic Data

The group studied consisted of 15 women (33%) and 30 men (67%), an over-representation of women compared with the statewide figure of 21% in 1976. The average age of workers was 40 years for the men, compared with 37 years for the women. The average educational level was 11th grade. Of the men, 24 (53%) were married, compared to 11 (24%) of the women.

The largest number of injured workers, 15 (33%), were in the construction industry, with government employees a close second at 13 (29%).

Throughout the State of Hawaii in 1976, government workers made up 23% of the work force and experienced 20% of the reported accidents. This study suggests that government workers in Hawaii County may be exposed to a somewhat greater risk.

It was surprising that in this community only 2 (4%) agricultural workers were studied. This is half the statewide average for agricultural accidents. Service industries contributed 8 (18%), transportation-communication-utilities and manufacturing, 3 each (7% each) and whole-sale-retail sales, 1 (2%). No injured workers were encountered in the finance, insurance or real estate industries.

Pre-Injury Status

A rough assessment of each worker's level of competence, overall stamina, and capacity to compete in the open labor market prior to the injury showed that 27 (60%) possessed a good level of employability, 14 (31%) fair, and only 4 (9%) poor. The general health picture was good in 21 (46%), fair in 12 (27%), and poor in 12 (27%). No prior history of overt psychopathology was found in 26 (58%) of the workers. Four (9%) had mild, 9 (20%) moderate, and 6 (13%) marked histories of psychopathology.

Among the workers without any history of overt psychopathology, scrutiny of their past histories, life situations, personalities and

psychological assessment revealed significant latent problems in 13 (29%).

Such findings point out the fact that rigorous screening and selection of employees according to clinically-based socio-psychological and health criteria might screen out some who would be valuable workers. The question is not, "Who shall be hired?" Except for the small percentage showing marked histories of psychopathology, the emphasis would be better placed on maintaining the worker once he is hired, trained, and on the job. Within this context, historical knowledge of the worker's health and life situation becomes very valuable.

Prior to his injury, how did the individual worker feel about his job? This study revealed that 32 (71%) had no pre-existing dissatisfactions or criticisms. Five (11%) were mildly, 4 (9%) moderately, and 4 (9%) markedly critical of some significant aspects of their work environment.

The Injury

The original injuries which ultimately led to psychiatric evaluation are shown in Table 1.

TABLE 1—Injuries

TYPE	NO.	%
Head	2	4
Neck & upper extremity	4	9
Chest	1	2
Back	12	27
Hand	1	2
Lower extremity	6	13
Multiple physical trauma	3	7
Physical collapse	1	2
Electric shock	1	2
Skin	2	4
Psychic trauma	12	27

Ten of the injuries were of a dramatic and harrowing nature which influenced the worker, his fellows, and his family in a variety of ways that in themselves warrant further study. The most evident result was heightened diffuse anxiety. Individuals overwhelmed by trauma may attempt to regain autonomy by sealing off the experience; but it is interesting, and perhaps sometimes accidentally therapeutic, that the compensation process requires frequent recounting of the event. For the most part, the workers in this series did not dramatize their injuries: much more impressive were the ways in which they evidenced a sense of increased vulnerability.

The psychiatric consultant would expect referral of workers who have experienced psychic trauma. It is remarkable, however, that the Department of Labor and Industrial Relations compiles no data on psychic trauma, and includes among the occupational diseases only "psychosis," with a statewide incidence of 0.5% in 1976.

The occupational psychiatrist also knows from experience that back injuries will be heavily



represented. Of this latter group all were involved in physical labor—lifting, bending, climbing, etc.—as skilled or unskilled construction laborers, practical nurses, or hotel workers. Such injury frequently eliminates the worker from the only job he knows how to do, with devastating effects on his mental health. Surgical treatment of on-the-job back injuries such as herniated intervertebral disc has been eminently unsatisfactory, but conservative treatment likewise yields a low level of vocational recoveries.

Across a gap of non-existent services, the psychiatrist becomes a resource to whom the acutely frustrated parties turn. By this time their defenses, distortions and projections are in full flower.

**Psychiatric Evaluation:  
The Referral Process**

Case finding is the keystone in any preventive effort. Vital questions in this study had to do with sources of referrals and the time lapse prior to mental health evaluation. In this series, the largest number of referrals, 18 (40%) came from attorneys. Personal physicians referred 16 (36%), and the remainder came from labor unions, 4 (9%); insurance companies, 3 (6.5%); self-referrals, 3 (6.5%), and employers, 1 (2%). The high incidence of attorney-generated referrals was consistent with the clinical finding that the workers, having often exhausted other sources of help, had assumed an adversarial posture with respect to their health status.

The average length of time between the injury and the initial psychiatric evaluation was 23½ months (Table 2).

TABLE 2—Referral Time Lapse

MONTHS	NUMBER	%
1 - 3	6	13
3 - 6	2	4
6 - 12	12	27
12 - 24	8	18
24 - 36	7	16
36 - 48	4	9
48 - 60	2	4
60 - 72	3	7
72 - 84	1	2

**Diagnosis**

The diagnostic entities encountered were predominantly stress reactions which, with time, crystallized as a psychoneurotic symptom complex. Pre-existing personality difficulties contributed significantly in some; a few cases were diagnosed in terms of the physical effects of the trauma itself (See Table 3).

**Areas of Stress**

The immediate clinical finding in this series was the exceptionally high level of distress. This

TABLE 3—Diagnoses

Occupational maladjustment	2
Adjustment reaction of adult life	2
Anxiety neurosis	5
Depressive neurosis	18
Hysterical neurosis	1
Mixed neurosis	5
Psychophysiologic musculoskeletal reaction	5
Hysterical personality	2
Psychotic depression	1
Narcotic habituation secondary to intractable pain	1
Post craniocerebral trauma	1
Chronic nonpsychotic organic brain syndrome	1
No disease	1

was expressed directly in symptoms related to the physical injury which had occurred in 75% of the workers. Physical pain was a prominent and persistent complaint. As Millman has noted:<sup>5</sup> "The question of whether the patient's pain is 'real' is a semantic trap. Subjective experiences are real and should not be challenged. Emotions that find organic expression may cause more pain than tissue damage." Closely associated to pain was a feeling of loss of contact with the job, fellow workers, and daily routines. Where the disability extended over a length of time, the worker felt isolated, often angry, and rejected if the company failed to maintain contact, and especially if some confusion arose about the receipt of disability benefits. During this time, frequently the only contact the worker had with his job was the treatment he received from his attending physician, whose reports would filter back to the employer, or more often, the insurance company. For the worker, on his own, to maintain contact with his work setting over a long period of disability was an uncommon occurrence.

Men workers, often in self-imposed confinement to their homes, and feeling guilty about being seen in public, generally experienced marked conflict with their wives. The financial security of the home was threatened, and an unhappy, physically uncomfortable husband was home all day, presenting complex needs wives often felt powerless to meet. In this series a rupture of the marital relationship or divorce resulted in 6 cases (17% of married workers). At the time of the evaluation, 12 marriages (34%) were under severe stress.

The worker who did not recover and return to his job found himself enmeshed in a protracted medico-legal process, the resolution of which is often measured in years. It is ironic that the process set up to protect the worker can become a part of the problem and that the legal and administrative systems themselves, and the delays in adjudication, might sometimes precipitate or aggravate a disability.

**Treatment**

The psychiatric consultant, given these patterns of stress, finds his assessment of an indi-

vidual case complicated by the worker's need for orientation to the process in which he finds himself. This appeared to be the most distinguishing feature in the psychotherapeutic management of the series of patients. The delays in the referral process tended to work against a collaborative effort with the employer in all but a few cases. With the passage of time, the array of therapeutic interventions available to a "case manager" immediately after injury shrinks down to only a few.

In this series, 16 workers (36.5%) were seen for brief psychotherapy, consisting of 8 or fewer visits. 9 (20%) were seen over an extended period, with visits scheduled at intervals up to 2 or 3 months. For the most part, therapy was of a supportive type and frequently involved the participation of other family members. Medication, when it was prescribed, included the mild tranquilizers and antidepressants. In some instances, medication was prescribed by the patient's personal physician, who collaborated in joint treatment. Community resources, such as vocational rehabilitation, were used wherever possible, but these were not helpful when problems had become chronic. For many of the workers, therapy was not initiated because chronicity of the condition worked against any clear-cut beneficial outcome.

Disability Rating

The majority of patients were referred because of active and unresolved psychological complications. Many came for an assessment, which included a rating of their level of disability. In every worker's compensation case, of course, a time is reached when a final rating will be made. The American Medical Association rating system<sup>5</sup> was used in this series, and is the basis for disability evaluation in the State of Hawaii. At this writing, 15 workers (33%) were still totally disabled on a temporary basis and not ready for rating. The ratings given this series are listed in Table 4.

TABLE 4—Disability Ratings

RATING	NUMBER	% OF SERIES
0	4	
2	1	Class 1 29%
4	1	
5	2	
10	7	
15	5	
20	3	Class 2 68%
25	1	
40	2	
45	1	
50	1	Class 3 3%

A disability rating of less than 10% was made in 29% of the workers. Rated between 10% and 25% were 57% and 14% were rated between 40% and 50%. Two workers were given ratings for

disabilities which were not job-related. In 9 (32%) of the cases listed in Table 4, an apportionment of the disability was made because of the blending of work-related and non-work-related health factors. The overall average disability rating was 15%. As an example, class 2 impairments for psychoneurosis (10-45% of the whole person) would encompass stress reactions of graduated intensity which modify patterns of daily living.

Disability ratings and labor board determinations bring the consultant into proximity with legal aspects of treatment and assessment of the injured worker. Time-consuming hearings actively discourage physicians who might otherwise become involved in providing such services. In this series, one bright spot was the fact that legal testimony was required of the author in only 3 cases in the entire series.

Outcome

Only 7 (16%) of the workers seen in this series returned to work. Two (4%) elected to retire without disability and 11 (24%) continued in a permanent disability status. At the time of this writing, the outcome of 25 cases (56%) is still undetermined.

Injured workers who returned to their jobs were more likely to have been referred for help earlier. The average lapse of time between injury and referral for this group was 5.5 months, compared to 23.5 months for the entire series.

Did the 12 psychologically injured workers fare better? In this series, the delay in referral averaged 16 months. Four returned to work and 7 remained disabled, although 3 of these had a good prognosis for eventual employability. One worker retired.

Discussion

Viewing the distress of the workers in the study group, one wonders about the overwhelming majority of injured workers who are not seen. The availability of psychiatric consultants on Hawaii has been extremely limited until the past few years, and this certainly discouraged referrals, although evaluation on neighboring Oahu must have been arranged at times.

It seems to be a moot question: Who is more uncomfortable about a psychiatric referral: The referring agent? Or the distressed worker? The psychic undercurrents of on-the-job physical injuries need to be thought of and explored early, when they are least likely to be received with resentment. The data regarding referrals of the workers in this series highlight a central issue, but certainly not an insoluble one.

The Committee on Psychiatry in Industry,<sup>4</sup> elaborates further on this subject:

"In this long, complicated, and contradictory process, the patient may be under the care of a number of physicians, each in his turn responsible for his treatment. Each



physician usually focuses upon physical malfunction and reinforces the need of the patient to prove and support his physical disability, thereby avoiding acceptance of a psychological cause for the problem. Hence, a number of parties including physicians, the patient, the insurance company, worker compensation systems, etc., may request consultation for second opinions to rule out a number of physical disorders. These all, in turn, contribute to reinforcing the pathology of the patient. All too often the psychiatrist is the last consultant to be approached. It is not unusual for 2 or 3 years to elapse before the psychiatrist is called upon. By this time, a 'traumatic neurosis' is apt to be well established and most resistant to successful intervention."

Possibly the worker's compensation program has played a self-defeating part in overlooking the psychosocial environment of the worker. We may have been lulled into a sense of complacency in the belief that, by legislative act, the injured worker is well cared for, and that a benefit mechanism goes into action immediately at the time of injury. The assurance of such a structure of monetary and medical benefits would seem amply to meet the need in a generous way, almost to the point of inviting abuse by the worker. Possibly this structure of benefits has created an unfavorable role for the injured worker as perceived by others. Whatever its components, it is an uncomfortable one for the concerned parties, but for the psychiatric consultant it has become familiar, anticipated, and emotionally laden.

Management and fellow workers are usually poorly qualified to assess the psychic status of an injured worker. The presence of medical and nursing personnel near the work site might provide the kind of communication which would foster greater understanding, but this is a rarity. An obvious physical injury in the presence of witnesses would seem to be a straightforward, readily grasped event for other workers. Often, the immediate responses of the injured worker and those about him are the first in a long series of spontaneous, unique, and frequently anti-therapeutic acts. Anyone who has seen injured athletes handled on the playing field, has heard the diagnostic pronouncements of the announcers from the distant boxes and has sensed the spirit of the crowd, has had an opportunity to experience a capsule version of the injured worker. In the case of the professional athlete, we are probably witnessing the best medical support available.

The injured worker's situation is far from this. How is management to view the worker who injures his back in the morning, works through the day, and calls in sick the next morning? An assessment of pain, unless promptly treated, cannot be made until the body's reaction over

several hours can be appreciated. If physicians differ on extent of pain and disability, surely management and fellow workers might rightfully be confused.

When emotional injury, ie, psychic trauma, is involved, the situation is even more unsettling and perplexing. Assault (with insignificant physical injury) upon a school teacher is perhaps more easily grasped, but if trauma is generated by a disturbed supervisor or foreman, and erosion of the worker's mental health occurs over a period of time, how is this to be viewed against the constantly changing tapestry of the worker's life?

On-the-job injuries constitute a "battle of statistics" among companies who place strong emphasis on eradicating such occurrences. Injuries may be pressured out of existence and go unreported to preserve a favorable record. The worker who spoils such a record may be angered to find his injury entangled in such cross-purposes. The supervisor who has been alerted by his men to a particular safety hazard is also in difficulty, balancing the multiple pressures of the job itself against the risks for his men. Such a situation becomes critical for the anxiety-prone or otherwise over-stressed worker, who is most likely to be the first to react maladaptively.

These varied examples are presented to highlight only a few of the emotional currents in many work situations and to suggest that the injured worker, having reached a point of incapacitation, no longer on the scene to speak for himself, may sometimes become typecast as a convenient scapegoat, a repository for the things that went wrong.

If management has a troubled view of injured workers, what of physicians who assume their treatment? In an attempt to shed further light on this question, the author surveyed 35 physicians in the community who would be likely to treat injured workers. Of these, 18 (51%) responded, estimating that they collectively treated 2400 injured workers annually. A total of 12 indicated their willingness to see such patients, 5 indicated they would rather not.

Among the unique features of injured workers, the majority of physicians reported complaintiveness, attention-seeking out of proportion to injuries, and prolonged recoveries. Hostility, blame of the employer, and suit-consciousness were mentioned. The physicians, with a few exceptions, felt their treatment results were less satisfactory, compared with non-industrial patients. A higher number developed chronic problems with poor results, compared with the same types of non-work-related injuries. The secondary gain of monetary compensation was frequently cited as working against recovery.

The responding physicians felt that present laws favor the worker too much, that awards are excessive, administrative processing too slow,

and communications poor. The requirement that, soon after any injury, an employer's representative inform the injured person of his benefits, did not seem to be carried out satisfactorily. Physicians with a monthly billing cycle found the legal requirement of a 3-week reporting cycle very burdensome. Several positive recommendations emerged: the injured worker should be fully informed of his rights and options as soon as possible, and preventive medicine should be stressed to the employers. Return to work should be positively reinforced and the employers should become more involved with their injured workers.

Pacific Telephone Company presents an enviable model for this type of involvement for all workers, injured or otherwise.<sup>7</sup> Supervisors are required to maintain weekly contact with workers who are off the job more than a week. After the second week, the medical department begins home or clinic visits to assess needs and facilitate or arrange necessary medical care.

### Conclusions

The data compiled in this study suggest the following tentative conclusions:

Hawaii County shows a disproportionate number of accidental injuries, industrial and otherwise. Government workers appeared more vulnerable, agricultural workers less. Prior to injury,  $\frac{2}{3}$  of the workers appeared to be quite employable and mentally healthy. The physical health picture was good in only half the workers. A very substantial majority were satisfied with their jobs.

Physical injuries to the low back and lower extremities predominated, with a significant number in whom the trauma was psychic. Referrals to the psychiatrist came primarily from attorneys and other physicians, and on the average, were delayed 2 years after the injury.

Diagnostically, most of the workers showed adjustment reactions or psychoneurotic patterns. The level of distress was exceptionally high, pain was prominent, along with numerous domestic shock waves, over-stressed marriages and divorces.

The various parties who deal with the injured worker may have negatively defined and institutionalized his role, and the worker himself needs considerable help from a coordinating

source to avoid winding up on the disability shelf.

Psychiatric treatment is most effective when given early, but if earlier still, might not be recognizable as psychiatric at all.

When disability ratings were given in this series, they averaged 15% of the whole person; of those in whom an outcome is known, 16% returned to work.

Physicians in this community who treat injured workers report the process to be difficult, problem-ridden, and generally unsatisfying as far as treatment results are concerned. From their vantage point and the author's, substantial positive preventive steps are needed.

This study indicates strong possibilities for a primary prevention program for workers, directed against the incidence of psychiatric complications following injury. Secondarily, there appears to be some promise for reducing and shortening morbidity associated with physical injury.

In a rural island community, a prime question is: who would perform such functions? The industries do not have their own medical departments; but small safety units, linked with community resources such as the American Red Cross, hospital emergency rooms, police, and Fire Departments could become fully versed regarding the psychological factors during and after an accident.

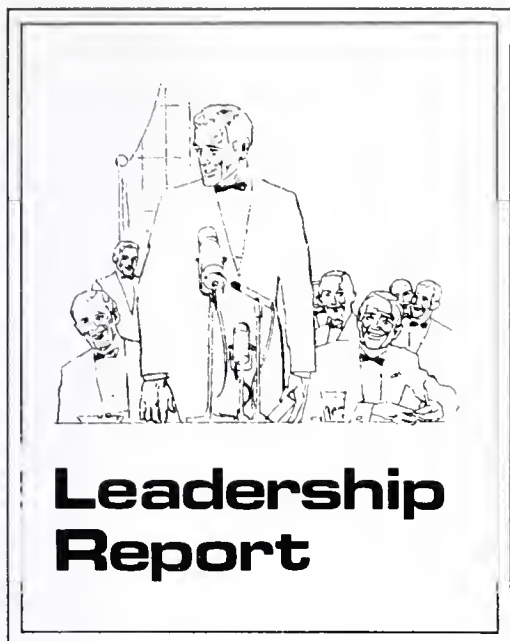
For more complicated situations, the Committee on Psychiatry in Industry proposes "a task force to serve as a rehabilitation team with the primary physician as the coordinator and director. This team would address itself to the needs of all those involved; the injured worker, the family, his fellow workers, his supervisor, management, the union, and all the physicians involved or those to become involved including the individuals responsible for worker compensation."

This team would have the primary task of integrating and coordinating efforts so as to aid in restorative efforts of the injured worker. Early in the process of treatment and restoration a psychological assessment is crucial. Of primary importance would be an attempt by this team to anticipate conflicts arising among various groups within the organization. The rehabilitation effort would become a mandatory process along legislative lines such as those enacted in California in recent years.

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5. Millman S: Managing intractable pain: resources and recourses. *Drug Therapy*, 65-80 (Oct) 1978.
6. Guides to the Evaluation of Permanent Impairment, Chapter XIII—Mental Illness. The American Medical Association, 1971.
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## Leadership Report

JON WON

### HMA COUNCIL BRIEFS

**Secretary reported** that as of May 31, 1979, HMA total membership had increased almost 4% from the same time last year.

**Proposed subcontract** by HMA with the Community Cancer Program of Hawaii (of the Cancer Center) to have the HMA develop and publish Outlines of Cancer Management in Hawaii for distribution to all physicians in the State and for placement in hospital wards and medical libraries, was turned down by the Council unanimously. Council felt strongly that such a project would, in essence, be issuing guidelines for cancer care and that this is not desirable.

**Because HMA is asked to respond** to frequent requests in the area of cancer as it relates to the Cancer Center, the Council asked that a committee of the HMA Executive Committee and the five past presidents draft a formal position statement for HMA to summarize its position on the Cancer Center and HMA's relationship with other involved organizations.

**Cancer Committee** recommendation to move the Hawaii Tumor Registry to the Cancer Center building died for lack of a second to the motion.

**Computer Study** report by consultants, Arthur Young & Company, was reviewed and accepted by the Council. Recommendation is that HMA, BME, and affiliated organizations enter into an automation plan with use of a mini-computer system shared by the HMA, BME, and affiliates, with the BME activities interfaced to a service bureau. Council authorized consultants to proceed with issuing a request for proposal and evaluation activities to be brought back to Council.

**HMA Council approved recommendation** to Department of Health that it consider reimbursement rate of \$60 per hour for physicians staffing Crippled Children Branch clinics. Current rate is \$28 per hour, and Council noted that recommended rate is considerably less than the physicians' usual charge but is in keeping with

reimbursement rates for other community services.

**Council approved CME Committee** joining the National Council of State Committees of CME.

**Honolulu County Medical Society** reported that its Recruitment Committee, citing the issue of high dues, had the Board of Governors adopt some proposed concepts: (1) rebate (or rebate in the form of credit) for regular members bringing new members into the Society; and (2) membership dues payments in installments. Further details need to be worked on; HMA Council referred report to HMA Finance Committee for review and report back to Council. AMA Trustee George Mills, M.D., will also be presenting concepts to AMA for consideration.

**Council authorized** the HMA reimbursement for the president or president-elect of each county medical society to attend the July 22-26, 1979, annual meeting of the AMA House of Delegates in Chicago. Council provides that such county representatives will be "working" at the meeting by covering the appropriate reference committees and providing testimony when appropriate.

### AMA HIGHLIGHTS—NATIONAL SCENE

**The Federal Trade Commission Staff**, after a three-year investigation, has recommended that the commission consider prohibiting physicians' organizations from controlling Blue Shield plans. Walter J. McNerney, president of the Blue Cross and Blue Shield Associations, responded that regulation would be "unnecessarily costly to America's taxpayers, potentially harmful to Blue Shield subscribers, and factually unsupportable."

The FTC said physicians control most Blue Shield plans, and these, in turn, decide how much physicians are paid for performing services. "Medical control of a plan means that physicians' organizations set or strongly influence the prices that their members will be paid by the plan," the report said.

McNerney said, "The FTC's theory that physicians on Blue Shield plans' boards increase health care costs is without foundation." Blue Shield statistical analyses show little or no correlation between physician representation on Blue Shield plan boards and health care costs to subscribers, he added.

The FTC report, McNerney said, ignores Blue Shield's history of cost containment programs as well as the fact that 62% of Blue Shield subscribers are already enrolled in plans with non-physician majorities on their boards.

**The March 1979 Update on a Continuing Study** on television violence, funded by the AMA and the National Institute of Mental Health, shows record levels of violence on network programs aimed at children. The study, from the U.

of Pennsylvania Annenberg School of Communications, also found that young people who are heavy viewers display an exaggerated fear and mistrust of the world. The researchers defined heavy viewing as more than four hours daily and violence as threatened or actual harm or murder.

**A Federal Court Ruling on Housestaff** collective bargaining was appealed by the National Labor Relations Board. The ruling by the U.S. Court of Appeals of the District of Columbia has, in effect, reversed the NLRB's 1976 finding that interns and residents are students who are not covered by the National Labor Relations Act. The Appeals Court ruling allows housestaffs to organize formally and engage in collective bargaining. In its appeal, the NLRB said the courts have no jurisdiction to review the NLRB finding that housestaff members are students and not employees.

**The Hospital Controls Bill Cannot Be Considered** an "anti-inflationary tool" because it would have no significant stabilizing impact on the economy, according to a study by Data Resources, Inc. The study, commissioned by Hospital Affiliates International, projects that at most the Administration's proposal would reduce the annual rate of inflation by one-tenth of one percent over the next five-year period. The Administration terms the bill its main weapon in fighting inflation in the general economy.

In recent testimony before the same Senate Health Subcommittee that approved the bill last week, Martin Feldstein, professor of economics at Harvard and president of the National Bureau of Economic Research, said the Administration's bill reflects "gross misunderstanding of the true nature of the rising cost of hospital care." He said the controls would not produce the savings claimed by the Administration but would result in substantial waste of the scarce resources used in the hospital industry.

**A New Cost Awareness Plan** involving 9,000 physicians on the staffs of the 125 hospitals owned by Hospital Corporation of America will build on the success of the Voluntary Effort, company officials announced. Called "Working Together," the program will stress increased emphasis on ambulatory care, cost-awareness education for physicians and consumers, material management, improved scheduling practices, and utilization review. The plan is described in the April issue of *Review*, published by the Federation of American Hospitals.

**HEW Asked Congress for the Power** to impose civil penalties against physicians and other health care providers who submit fraudulent Medicare or Medicaid claims. The proposal would allow HEW to impose a \$2,000 penalty after a hearing showed the claim to be fraudulent. The penalty could be appealed in the courts, but HEW could assess the fine without first get-

ting the Justice Department to prosecute the offender.

Criminal penalties already exist for Medicare and Medicaid fraud, but, HEW Secretary Califano said, "the civil penalty would help us move quickly against the defrauders when criminal prosecution may not be warranted or practical, or when fast administrative action is necessary." Accused persons would be entitled to an HEW hearing with legal representation.

**The Overall Rate of Inflation Shot Up** by 1.1% in April, more than twice the rate of increase in the medical care component of the Consumer Price Index. For the third straight month the all-items index of the CPI reached 1% or higher. The medical care component increased 0.5% in April. Physicians' services rose 0.7% and hospital room charges rose 0.3%.

During the past three months the all-items index rose at an annualized rate of 14%, while the medical care index went up 7.8%. Over the past 12 months the all-items index rose 9%. The annualized rate of increase in physicians' services was 8.1% for the past three months and 8.9% for the 12-month period.

**The AMA's Program to Help Improve Health Care** in the nation's jails will be continued under a \$1,296,460 contract with the Law Enforcement Assistance Administration of the U.S. Justice Department. The Association will provide technical assistance to facilitate widespread adoption of health care standards developed by the AMA for correctional institutions. Sixteen state medical societies, using staff and volunteer physicians are now working to implement the program at the state level.

**During the First Four Months of the Year**, the AMA presented testimony or statements on 39 occasions and on numerous issues before Congress or federal executive agencies. The subjects ranged from cost containment to recombinant DNA and from the confidentiality of medical records to nutrient labeling for food products. In 1978 the AMA testified or submitted statements on 94 occasions.

**A Program to Oversee the Activities of Regulatory Agencies** is long overdue, the AMA told Congress in a letter supporting the Sunset Act of 1979. The bill would make federal programs and funding subject to mandatory review by Congress at least once every ten years. In a letter to Rep. Gillis W. Long (D-La.), chairman of the House Subcommittee on the Legislative Process, the AMA said the "sunset" concept is a needed step toward stemming the "tremendous proliferation of regulatory activities in the Executive Branch of the federal government." The AMA urged that the inflationary impact of regulations be evaluated and that the least inflationary alternative selected whenever possible.

**The American Hospital Association will File Suit** to keep HEW from implementing re-



vised charity care regulations in the Hill-Burton program. The regulations would eliminate the "open door" option for Hill-Burton compliance and would require hospitals to provide specific dollar levels of charity care each year for the remainder of their 20-year obligation periods. The dollar amounts would be adjusted annually in line with changes in the medical care component of the Consumer Price Index.

In announcing the suit, AHA President J. A. McMahon said the new regulations breach the long-standing agreements that hospitals have had with HEW for satisfying their obligation that a "reasonable" volume of charity care be provided by facilities receiving Hill-Burton construction funds. "Now, however, HEW seeks to expand the obligation far beyond what is reasonable," he said.

McMahon disputed HEW Secretary Califano's characterization of the added services under the new rules as "free care." The AHA official said there is no such thing as free care. He pointed out that the revisions will cost hospitals another \$97 million in the next fiscal year, as estimated by HEW. That cost will have to be passed on to private hospital patients, he said.

**An AMA Motion to Eliminate a Demand** for \$10 million to fund a research institute was granted by the Federal District Court in Chicago as a partial summary judgment in an anti-trust suit brought by five chiropractors against the AMA and 15 other defendants. The suit, which was filed in 1976, charges the defendants with conspiring to restrain licensed chiropractors from competing in the delivery of health care services. The chiropractors seek a permanent injunction, triple damages, attorneys' fees and costs. No date for trial of the case has been set.

**WANTED:** Staff physician, beginning July 1, 1979, for City and County of Honolulu Department of Health. Involves shift work, mostly days (a.m.). Allowable to work elsewhere. Salary range of \$18,000 to \$27,000 depending on experience. Interested physicians call: Dr. S. Tyau, Senior staff physician, 737-3188; Mr. John McDonald, Director, C&C Health Department, 955-8188; or Mr. Dan Chock, C&C Civil Service Director, 523-4302.

**POSTGRADUATE PROGRAM:** Scottish Rite Hospital for Crippled Children, Second Annual Postgraduate Course: "Pediatrics in Review—1980—The School Age Child." January 13-19, 1980, Acapulco, Mexico. Speakers will include: James F. Schwartz, M.D., Professor of Neurology, Emory University; Nathan J. Smith, M.D., Professor of Sports Medicine, University of Washington; William B. Strong, M.D., Director of Pediatric Cardiology, Medical College of Georgia and others. For information contact: Judson Hawk, Jr., M.D., Scottish Rite Hospital for Crippled Children, 1001 Johnson Ferry Road, Atlanta, Georgia 30342.

**NATIONAL HEALTH INSURANCE:** At the 1978 Interim meeting of the AMA House of Delegates, Resolution No. 62—National Health Insurance was adopted. This resolution authorizes the AMA Board of Trustees to draft a bill, only if necessary, based on the four principles in Resolution 62 which are:

- (1) Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and co-insurance.
- (2) A simple system of uniform benefits provided by the federal, state and local government for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, financial hardship, etc.) not to be able to provide for their medical care.
- (3) A nationwide program by the private insurance industry of America (and government if necessary for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and coinsurance to make it economically feasible and to avoid abuse.
- (4) A program developed pursuant to these principles should be administered at the state level with national standardization through federal guidelines.

#### MEDICAL MANAGEMENT PROGRAM

- ♦ *Billing procedures that produce results*
  - ♦ *Insurance processing and follow-up procedures*
    - ♦ *Computer softwear analysis*
      - ♦ *Personnel efficiency analysis, training, policies, etc.*
        - ♦ *Inter-office communications*
          - ♦ *File systems and chart control*

Verne Miller, MGMA, ARMA  
Professional Management Services

Amfac Center  
523-2923



## Hospitals of State

"The Department of Health is responsible for the operation of hospitals in areas where the private sector is **unable to provide** appropriate services . . ." (Narrative Annual Report, Hawaii State Health Department, 1978.)

To carry out this self-imposed mission, the County/State Hospitals Division lost \$11.5 million operating its 13 facilities last year.

This wouldn't be so bad, if it were necessary. But the "private sector" has repeatedly tried to purchase many of the state hospitals, with a view to operating them properly and profitably. These hospital management corporations have generally excellent records, and a proven ability to "provide appropriate services." Yet the Hospitals Division has refused to relinquish control, continuing to bleed the State treasury of \$32,000 every single **day**, while hospital staffs complain of crumbling facilities and morale.

The State should be in the hospital business (or **any** business for that matter) only when there is an overwhelming unmet public need, and only for so long as that need remains unfilled. Since most of these community hospitals have long since outgrown their rural status, they no longer require private duty nursing by a paternalistic bureaucracy.

This anachronistic political fiefdom should be dismantled forthwith, and sold to the highest bidder. With first-class medical and business management, service and morale can only improve, while at the same time stopping further fiscal hemorrhage.

J.M.C.

## No Squeak, No Oil

The State Legislature in its wisdom recently realized that there's not enough money to support Hawaii's indigent and indolent in the manner to which they aspire, because the welfare rolls continue to enlarge faster than the supply of money.

There's no way to cut costs when you let more recipients feed at the trough every year, and nobody seems able to restrict the increasing numbers of newly-needy.

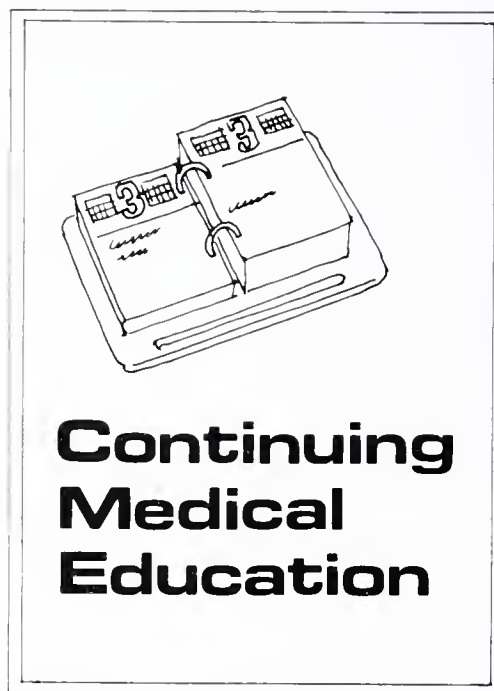
Since the price of food and rents keeps climbing, the DSSH can't reduce the handouts, lest the recipients find themselves hungry or homeless; many might be forced to work.

But physicians' services are one area that **can** be controlled, because we are paid directly: take it or leave it. So to compensate for other increases which they cannot control, our lawmakers simply chopped medical payments back to the levels of four years ago. Eureka!

The legislature wouldn't dare ask Foodland to give welfare recipients a 60% discount, but it expects physicians to do so. In effect, we are told that our services are worth less than the valuation we place on them. How long will we stand for it? Dr. Sanford Marcus of the Union of American Physicians told HMA members five years ago that ". . . one day you **will** form a union, either now while you still have a little bargaining power left, or later when we physicians have been destroyed as an economic force."

Well? How strong is our bargaining power at the Capitol? How long **will** we stand for it?

J.M.C.



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.



### **John A. Burns School of Medicine**

1. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
2. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
3. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
4. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.

### **Hawaii Thoracic Society**

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. 3rd Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

### **Hickam Clinic**

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

### **Hilo Hospital**

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat): not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

### **Kaiser Hospital**

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
  2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
  3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
  4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
  5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

### **Kapiolani-Children's Medical Center**

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

### **Kuakini Medical Center**

1. G.I. Conference, 1st Tuesday, 8:00-9:00 a.m.
2. Nephrology Conf., 4th Wednesday, 8:00-9:00 a.m.
3. Oncology Conf., every Thurs. 7:30-8:30 a.m.
4. Surgical Conf., 1st, 2nd, & 3rd Fri., 12:45-1:45 p.m.
5. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 12:45-1:45 p.m.
6. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, 1:00-2:00 p.m.
7. Ophthalmology Department Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.

### **Maui Memorial Hospital**

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd.—Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., 3rd Mon., 7-8:00 a.m.
4. Family Practice Section—3rd Wed. 7-8:00 a.m.
5. Diagnostic Radiology—4th Tues., 12-1:00 p.m.

### **The Queen's Medical Center**

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium  
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium  
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium  
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

### **St. Francis Hospital**

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Hematology Conf., 3rd Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
7. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

### **Straub Clinic & Hospital**

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

### **Wahiawa General Hospital**

1. Noon Seminars, Every Tuesday

### **Wilcox Hospital (Lihue)**

1. Department of General Practice Meeting—last Wednesday

2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: I, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

## SPECIAL EVENTS

Aug. 4-11, 1979 Ophthalmology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.

Aug. 8-22, 1979 22nd Annual Postgrad Refresher Course, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Cosponsor: U of HI. Held: Honolulu, Maui & Kona. 39 hrs.

Sept. 9-17, 1979 Practical Management of Anesthetic Problems, USC Sch of Med., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 31¼ hrs.

Oct. 8, 1979 HI Thoracic Society—Annual Mtg. 7:00 p.m. Fireside Chat, 7:30 p.m. 2 hrs. CME Cat. 1—Ilikai Htl. Honolulu. Contact: R. Respicio (808) 537-5966 for further info.

Oct. 8, 12, 1979 123rd Annual Convention-HMA/AMA Regional Mtg. Ilikai Htl. Honolulu. 5 days. Contact: HMA Office (808) 536-7702.

## OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA office.

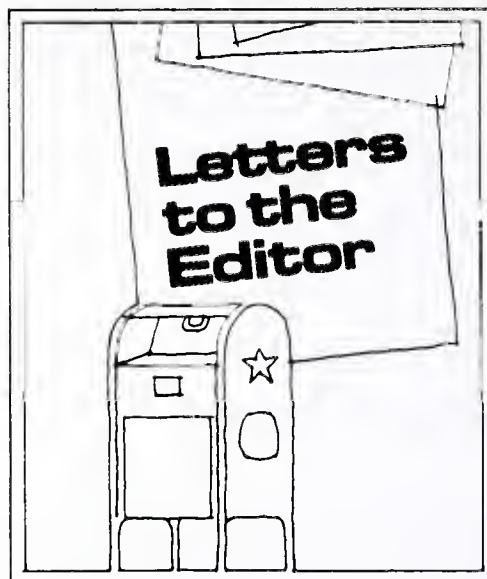
## ANNOUNCEMENT

January 12-18, 1980

**15th International Surg. Congress—(10 Surg. Spec.) Cat. I—20 hrs. Held at Sheraton Waikiki, Honolulu, Creative Assoc. Chgo, IL. Contact: Pan Pac. Office—236 Alex Young Bldg. Honolulu or Charlotte (808) 536-4911.**



"No, no Ashby! You're pronating the supinator longus. said extend your carpi radialis and flex the deltoid."



To the Editor:

Thank you for your letter of February 26, apropos the topic of the insidious "Polish joke" and your journal. While I am pleased that you will print a reply in one of your issues, I am not too happy over your statement: "Ethnic jokes are best when told by a member of the victim's own ethnic group, but they are not as grossly offensive in my opinion, as you believe them to be." I think you miss the point entirely, and this distresses me, because it is precisely this which is missed by the whole lot of users of such jokes to spice up their dreary lives. The point is this: Did you ever consider the injury and hurt, single and cumulative, such jokes can cause to children? To hear your own kind made the butt of, the laughing stock, the image of loutishness, ignorance, etc? and not being able to see any connection in it with what actually is. I know, for I have an 8-year-old myself and I get his searching and puzzling questions from time to time. Peer pressure is a powerful thing, as you know. An adult can defend himself, strike back, but a child? And this is why we should put a stop to all such slurs of whatever race or color or ethnic heritage involved—for the sake of our children, our future citizens, and leaders of the country. We perpetuate our own secret enmities and prejudices, boil off our own short-comings and frustrations by relying on "the joke," seeking a scapegoat. It can lead to no good. And the so-called 'humor' of the joke—it is banal, demeaning.

As to your many Polish friends who are of your mind, well, it seems to me that there is always something to learn in life, at whatever age or level of achievement, something always to discover. And besides, if you really meant what you said in your letter to me, then why is it that no Black jokes or Jewish jokes are printed? What judgment is it that selects, chooses, and for what reason?

Yes, you owe it to your readers not only to print your reply but to desist entirely from printing such jokes in your journal. Your December issue, by the way, was no better.

Thank you for your attention to my request. I am,

Sincerely,

EDWIN P. KULAWIEC, Ph.D.

Associate Professor of Education

The George Washington University

Washington, D.C. 20052

P.S. You may want to know that my article on a Polish doctor will appear in a forthcoming issue of JAMA.



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Amount of Loan	Annual % Rate	No of Monthly Payments	Monthly Payment Amount	Total of Payments* (Principal & Interest)
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\$10,000	11.88	180	119.25	21,465.00
\$15,000	11.88	180	178.87	32,196.60
\$20,000	11.88	180	238.49	42,928.20
\$25,000	11.88	180	298.11	53,659.80

\*Total of payments may vary depending on the date of the month payments are received

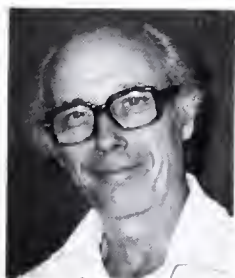
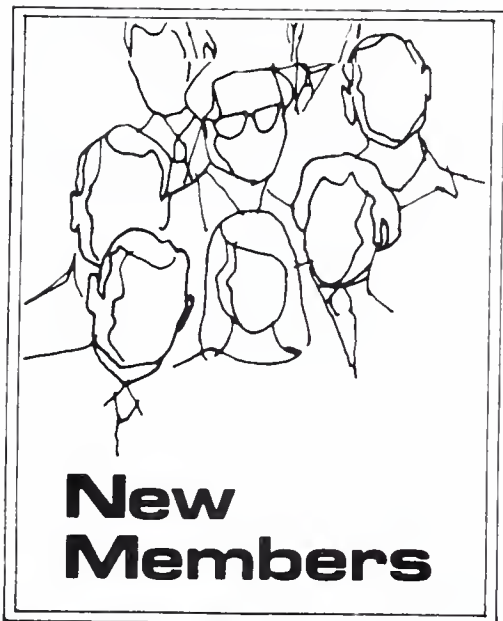
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**Thomas C. Hall, M.D.**

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INTERNAL MEDICINE and  
ONCOLOGY



**Steven T. Komura**

University of Hawaii  
John A. Burns School of Medicine  
Honolulu, Hawaii 96822

STUDENT



**Stuart L. Rusnak, M.D.**

1319 Punahou Street  
Honolulu, Hawaii 96826

ALLERGY



**Friday, May 4, 1979**

**HMA CONFERENCE ROOM**

**PRESENT:**

Drs. Goto, Bell, Hindle, Iaconetti, Chang, Azman, Bruce, Cahill, McNamee, Clingan, Fu, Wigle, Mills, Kuboyama, Dang, Sia, Simmons, Mr. V. Thomas Rice, and Mrs. Nancy Simmons. HMA Staff present were: Mr. Won, Mr. Saranchock, Mr. Leineweber, Mr. Ajifu, Mrs. Kendro, Mrs. Chang, Mr. Ontai, Mrs. Wong, and Mrs. Young.

**CALL TO ORDER:**

The meeting was called to order by President Goto at 6:05 p.m.

**MINUTES:**

The minutes of the previous meeting were approved with correction.

**REPORT OF THE TREASURER:**

The March 1979 financial statement was reviewed in detail and approved subject to audit.

**REPORTS OF COMMITTEES  
AND COMMISSIONS:**

*A. Request from Community Cancer Program of Hawaii:* On behalf of Cancer Committee Chairman, Dr. John Keenan, Mr. Jon Won reported that HMA representatives had met with CCPH representatives to pursue the possibility of a HMA subcontract under the



## **BLEMISHES?**

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*Lydia O'Leary*  
**OF HAWAII**

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Community Cancer Program of Hawaii. Activities projected are:

- (1) to provide administrative support to Hawaii radiologists in bringing an American College of Radiology course to Hawaii to train and certify physicians as A and B readers in the diagnosis of pneumoconiosis (relating to asbestos follow-up);
- (2) to design and implement Colonoscopy/Sigmoidoscopy training enhancement for medical students, housestaff, and interested practitioners;
- (3) to establish a Cancer Medical Information Line for use by physicians and other health care professionals in obtaining technical information about cancer;
- (4) to publish and develop Outlines of Cancer Management in Hawaii; and
- (5) to develop Providers Personal Cancer Control Program.

Under the proposal, HMA would be required to contribute matching funds/in-kind services, since monies of the Community Cancer Program are awarded on a matching basis. The Council was informed that the final draft subcontract is not yet available; however, CCPH protocol calls for any proposal to first be reviewed by its Planning and Development Committee (which will meet on May 11). The Cancer Control Council will meet on May 24, at which time a decision will be made on all projects for the July 1 cycle.

In view of the May 11 deadline, a request was made that the Council approve entering the subcontract with the CCPH, subject to review and approval by the HMA Cancer Committee which will meet on Tuesday, May 8.

**ACTION:**

**It was moved, seconded, and passed that the subcontract be referred to the Cancer Committee.**

*B. Public Affairs*

*1. TV-Radio:* Dr. Phillip McNamee and Dr. John Corboy gave the Council an update on activities of the TV-Radio Committee. The Council reviewed a video presentation of "Your Body, Your Mind," containing excerpts of programs produced under the Chamber of Commerce grant. While a 40-show series was produced this year, the Committee plans to have a 26-show series this coming year—producing 13 new shows and taking the 13 best shows from the previous year.

In the near future, the Committee will be approaching foundations and organizations in the community to seek funds for production of the new series. It was pointed out that promotional funds are needed to publicize the series; however, such funds are minimal or rarely granted by private groups. On behalf of the TV-Radio Committee, Drs. McNamee and Corboy requested that the Council approve an additional allotment of \$2,000 for this year for promotion of the "Your Body, Your Mind" series and that the budget submitted to the 1979 House of Delegates in October include a budget of \$5,000 for the TV-Radio Committee.

**ACTION:**

**It was moved, seconded, and passed to approve an additional allotment of \$2,000 for the TV-Radio Committee.**

*2. Health Fair:* Dr. McNamee reported that the Public Affairs Committee has made preliminary inquiry with the Neal Blaisdell Center regarding dates available in 1981 for the HMA Health Fair. Dates presently under consideration are the first two weeks in October. Dr. McNamee recommended that the Council authorize funds, for use as a deposit when HMA is ready to make a commitment, to permanently hold dates at the Neal Blaisdell Center.

**ACTION:**

**It was moved, seconded, and passed to approve the expenditure of \$1,000 to permanently reserve dates for the Health Fair at the Neal Blaisdell Center.**

*C. Legislative Committee:* Dr. E. Lee Simmons reported that the Legislature passed and sent to the Governor bills which will provide for: mandatory generic drug substitution, lowering of the initial trust corpus of HAPI, minors' rights to family planning services without parental consent, SHPDA to establish criteria to exempt certain physicians' offices from the Certificate of Need requirement, rubella testing of marriage license applicants with sunset clause of five years (upon approval of private physician, DOH will provide follow-up and immunization of susceptible women).

The Council was informed that H.B. 605 was sent to a conference committee at which time \$8 million was cut from the Medicaid budget. The Legislature also mandated, in accordance with the new legislation passed, that providers be reimbursed based on 1975 profiles. It was recommended by the Legislative Committee that the Governor be made aware of HMA's sentiments on the Medicaid bill and that a letter of protest be sent to each legislator.

**ACTION:**

**It was moved, seconded, and passed that HMA communicate with the Governor to ask that he veto H.B. 605 and that a letter be sent to each legislator.**

Dr. Simmons noted that the Legislative Committee has been exploring the possibility of hiring a part-time lobbyist for the next legislative session, and to date one interview has been conducted.

The Council reviewed HMA's 4/27/79 response to Senator Spark Matsunaga's request for comments on S. 350 and S. 351 relating to catastrophic health insurance.

Dr. Philip Hellreich, Chairman of the Subcommittee on Malpractice Law, reported that the committee has been studying the malpractice situation in Hawaii. The Committee recommended that the Council approve the expenditure of \$600 to pay for the plane fare and hotel accommodation for a representative to visit the Pennsylvania Medical Society to learn more about its experience with malpractice insurance.

**ACTION:**

**It was moved, seconded, and passed to approve the expenditure of \$600 for the plane fare and hotel accommodation for a representative to visit the Pennsylvania Medical Society.**

*D. Emergency Medical Services:* It was reported by Dr. William Dang that the EMS Program has been meeting with the Board of Medical Examiners to reiterate HMA's position regarding changes desired under Act 148 for certification of paramedics by the

Board of Medical Examiners, rather than by the Department of Health. It is felt that paramedics should be certified by the same body which licenses physicians, since they function as physician extenders. EMS Program representatives will meet in the near future with the Director of the Department of Regulatory Agencies.

*E. Medical Education:* Dr. Nadine Bruce reported that the CME Committee is experiencing some difficulty in controlling program co-sponsorships, especially in the areas of publicity and submission of attendance records to HMA. As a condition of co-sponsorship, the Committee has instituted a requirement for sponsoring organizations to provide the HMA with a proof copy of any brochure or advertisement for the CME Committee's review prior to printing, to ensure that the advertisement has been prepared appropriately.

*F. Computer:* Mr. Won commented that within the next week, Arthur Young and Company will submit a final report on its feasibility study on possible automation of HMA and related organization's activities. It is anticipated that the Ad Hoc Committee on Computers will meet to review and discuss the report with representatives of the consultant firm, and a report will probably be presented at the June Council meeting.

*G. 9% Solution:* Mrs. Becky Kendro reported that Dr. Donald Char will represent HMA at the next 9% Solution meeting on May 25 and 26 at the Ala Moana Hotel. Slated for discussion is the topic of health manpower.

### REPORTS OF COUNTY SOCIETY PRESIDENTS:

*A. Hawaii:* Dr. Arch Wigle, Councilor for Hawaii County, mentioned that the Society is seeking information regarding resources available to Hawaii County physicians to obtain Category 1 CME Credit.

*Honolulu:* Dr. Walter Chang reported that Dr. Peter Singleton, rheumatologist for the Letterman Army Medical Center, will be the guest speaker at Honolulu County's general membership meeting on May 29, 1979. The Board of Governors will meet on the same evening, followed by Dr. Singleton's presentation and a wine tasting session (provided through the courtesy of McNeil Laboratories). Military physicians, medical students, and residents are also invited to attend this meeting.

*C. Maui:* Dr. Ben Azman reported that the Society will hold its fifth meeting of the year on May 15, with Mr. James Swenson, SHPDA Administrator, as the featured speaker.

### OTHER BUSINESS:

*A. Auxiliary:* HMA Auxiliary President, Mrs. Nancy Simmons, reported that the Auxiliary is collecting outdated PDRs for the EMS Program.

*B. Rehabilitation Act of 1973:* It was brought to HMA's attention that since the Association is receiving Federal funds, HMA may be subject to Rules and Regulations, Section 504 of the Rehabilitation Act of 1973. Mr. Won summarized that the rules and regulations provide that the premises of such organizations receiving Federal funds be accessible to the handicapped. The matter was referred to Mr. Rice's office for review, and it was legal counsel's opinion that there would be no need to make structural modifications to the HMA building.

### ADJOURNMENT:

The meeting was adjourned at 9:10 p.m.



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5. We discuss the position with the applicant before setting up an interview in order not to use up your valuable time - with someone not interested or qualified.
6. Follow-up after each interview - we cannot assume that both parties are communicating and things are going well.

"Placements don't happen, they are made!"

*Paul S. Isenburg*  
Paul S. Isenburg, Ph.D.  
Director  
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686



## Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

**New Members—George Gay MD** is a new Active member by transfer from San Francisco, ABFP 1977; he will be practicing in Hilo. **James E. Mitchell MD**, old-timer of Kona on the Big Island, has joined as an Active member. We are honored by their joining.



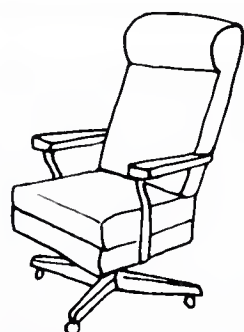
**Members Dropped**—for failure to keep up with CME requirements: **Steven Strong** of Lahaina, and **Edwin "Buzz" Willet** of Kamuela. We're sorry to see them give up.

**News of Members**—Our President of 6 months, **Dave Swanson**, the first Military President we have had, has suffered the fate of all military personnel: Uncle Sam calls and he has to go to his next assignment. He leaves on 27 June for Ft. Bragg, N.C., where he will be Chief of the Medical Staff at Womack Army Hospital. Good luck, Dave, and a warm Aloha to you and the Missus from all of us in Hawaii! **Pat Dietrich** will serve out Dave's term as President before she takes over in her own right; she is now Pres-elect. **Tom Cahill** will serve as Delegate to AAFP, taking Felix Lafferty's place that he held for 12 years. **Jim Tsuji** is the one and only alternate so far. Anyone care to apply for the other if **Fred Dodge** cannot go to Atlanta in October? **Don Farrell** is our other Delegate. **Gary Sunada MD** is now a Resident Affiliate member, after having been a Student member; he has his MD from UHSM. Gary will be a Resident at Memorial Hospital in South Bend, Indiana.

**Eligibility**—for membership in AAFP consists of a) 3 years of Family Practice Residency, b) 2 years of accredited graduate training plus 2 years of active family practice, or c) 1 year of accredited graduate training plus 3 years of active practice.

**HCMS**—is asking for volunteers from the Family Physician to be on its Speakers' Bureau list. Any member anxious to serve, please contact John Won at the HMA/HCMS office.

**CME**—Keep in mind and send in your registrations for the British Columbia Chapter of the College of Family Physicians of Canada joint meeting with HAFP February 1 to 4, 1980 at the Hilton Hawaiian Village. The deadline to sign up for 32 "P" of Core Content Review is 31 August 1979. The deadlines to sign up for the Georgia AFP's "Newborn Course" is 6 July 79 and for its "Geriatrics Course" 9 July 79. Remember the Big One: The USC-UH-TAMC 22nd Annual Postgraduate Refresher Course at the Sheraton Waikiki and on Maui and Kauai August 11 to 22 this Summer.



**Clinical  
Pathologist's  
Easy Chair**

FRANCIS FURUNAGA, M.D.

### Bilirubin

Bilirubin is the degradation product of hemoglo-

bin with small amounts from other nonheme porphyrins. It is formed in the reticuloendothelial system and carried by albumin to the liver where it is conjugated with glucuronic acid and excreted into the intestinal tract via the bile canaliculi and excretory duct system. Most of the bilirubin is converted to urobilinogen by the intestinal flora but a small fraction is hydrolyzed and reabsorbed.<sup>1,2</sup>

The normal liver efficiently disposes of bilirubin from the blood and maintains a serum level of less than 1 mg per dl. Clinical jaundice is usually noted when the serum level is greater than 2.5 mg per dl. Van den Bergh discovered two types of diazo reactions when he added Ehrlich's reagent to sera from jaundiced patients. The color developed within 30 seconds in the serum from a patient with obstructive jaundice (he called it "direct" bilirubin) and the serum from a jaundiced patient with hemolytic anemia required addition of alcohol for color formation (he called this "indirect" bilirubin). It has been shown that the indirect reacting bilirubin is unconjugated or 'free' bilirubin while the direct-reacting portion is made up of bilirubin diglucuronide plus a 1:1 mixture of 'free' and the diglucuronide.

Since bilirubin is conjugated in the liver parenchymal cell and excreted by the excretory system, conjugated bilirubin should not leak into the blood from the normal liver. The liver cells retain their ability to conjugate bilirubin in liver disease but much of this conjugated form leaks into the blood. There theoretically should not be any conjugated bilirubin in the blood of normal individuals but there is a small amount detected due to the nonspecificity of measurement of conjugated bilirubin. With most accepted methods, the direct bilirubin should not exceed 0.40 mg per dl.

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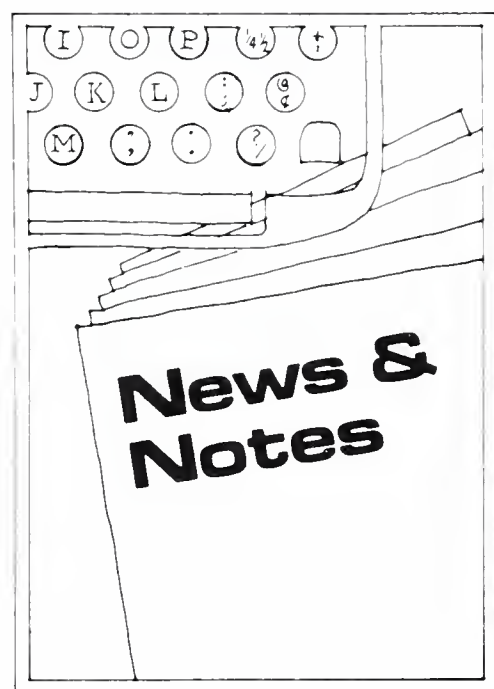
**TRASK/DENIS REAL  
ESTATE CORP.**

Increase of bilirubin concentration occurs as a function of fasting.<sup>3</sup> Total serum bilirubin begins to increase 5 to 10 hours after the last meal and increases progressively. In normal individuals, the increase after a 48-hour fast averages 240% and in patients with hepatic dysfunction such as Gilbert's syndrome and cirrhosis, the average increase is 194%. The diurnal rhythm of bilirubin with the highest levels in the mornings is related to the overnight fast and it can be suppressed by frequent nocturnal feedings. A 48-hour fast is not unusual in very sick patients, especially after surgery.

Bilirubin may also be increased in septicemias, following strenuous exercise, alcohol ingestion, some cases of pregnancy and in some patients who use oral contraceptives. Jaundice may occasionally complicate major surgery. There are many possible causes such as transfusion of stored blood which invariably begins to hemolyze within 24 hours, especially if more than two weeks old, hepatocellular impairment due to anesthesia, drugs, shock, hepatitis, and sepsis.<sup>4</sup>

#### REFERENCES

1. Robinson SH: The origins of bilirubin. *New Eng J Med* 279:143-149, 1968.
2. Menken M et al: Bilirubin production and excretion: *JAMA* 198:1273-1276, 1966.
3. Barrett PVD: Hyperbilirubinemia of fasting. *JAMA* 217:1349-1353, 1971.
4. LaMont JT, Isselbacher KJ: Postoperative jaundice. *New Eng J Med* 288:305-307, 1973.



## Professional Moves

We may be in a hurricane's eye for we find only sporadic news about physician activities . . . In April, OB Gyn man **George Shimomura** opened his Aiea office at the Aiea Medical Building, 99-128 Aiea Heights Drive . . . In May, pediatrician **Vincent McCarthy** joined the Straub Clinic & Hospital at its Aiea office and **John Edwards Jr.** and his Urology Clinic, Inc. relocated to Kapiolani Children's Medical Center from the Pan Am Bldg. Gastroenterologist **Edward Nobuo Kanda** joined the Central Medical Clinic . . . On the Garden Isle, psychiatrist **Gary Blaich** opened his full time practice at G.N. Wilcox Memorial Hospital & Health Center . . . In June, **Gunther Hintz** and Plastic Surgery Hawaii Ltd. relocated their main office to the Kuakini Medical Plaza, Suite 601 and FP **Joseph Hennessy Jr.** opened his office at 53 Puunene Ave., Kahului, Maui . . .

Incidental Intelligence: Busy pediatrician **Masato Hasegawa** is running a full time practice and also working for a doctorate in economics at the U.H. in his spare time . . .

## Elected, Honored, & Appointed

We were pleased to learn that **Andy Morgan** has been elected President of the Western Section of the American Urological Association for 1979-80. The group is planning its annual meeting in March 1980 at both Kona and the Waikiki Sheraton . . . **Masaru Koike**, golf committee chairman personally went out to test the Waikaloa Golf Course to see if it would be befitting the urologist golfers . . .

**Richard Adler**, Hilo pediatrician and assistant clinical professor of pediatrics at the John Burns Medical School has a television program and a newspaper column called "Medical Matters." Richard was recently elected chairman of the board of trustees of the Media Institute of Medicine. The Institute located at 1833 Kalakaua Ave. devotes itself to research, development and creative activity in the area of health education and was formerly chaired by **Ron Pion** who has accepted a position with KNBC Television in LA as a media physician investigating new developments in health care . . .

**Fred M.K. Lam** has completed the education requirements needed to retain active membership in the American Academy of Family Physicians . . . And so has **Arch Wigle** of Ka'u . . . Neurologist **Robert Bart** of the Muscular Dystrophy Association Clinic at Kapiolani-Children's Medical Center attended a national conference of MDA clinics in St. Louis, Mo. . . The highlight of the conference, attended by 250 MDA clinic directors from all over the U.S., was discussion of a new treatment for myasthenia gravis called plasmapheresis . . . (which has already been used at St. Francis Hospital)

## Oncology Dialogue

A 58-year-old caucasian man had "flu-like" symptoms for two weeks with chills, fever, morning diarrhea, 20 lb. weight loss, Rt iliac crest pain and RLQ tenderness . . . BE showed a cecal mass with perforation . . . Bone and liver scans were negative . . . At surgery, he had a Duke's B CA of the ascending colon with perforation. The tumor was resected and the colon anastomosed end to end . . . Post operatively, the patient did well and the plan was to give a dose of radiation to the perforation site to stem any tumor spillage. Moderator **Quint Uy** asked whimsically, "Ed, do you plan to burn him?" Radiotherapist **Ed Quinlan** retorted rather emphatically, "I don't like the term 'burning people'" A sympathetic oncologist added, "Kinda like saying 'poisoning people' with chemotherapy." Quint apologized, but seemed quite pleased at the reaction he had caused . . .

## Sportsmen

### Tennis

The dentists are riding high in the aftermath of the 3rd Annual DDD Tennis tournament held on the windy courts of the Honolulu International Country Club. Play was divided into two classes, Open and Novice with 15 teams participating in the Open Match Play . . . Our **Ben Chang** teamed with **Dennis Maehara** were runners-up to the dental doubles champs: Dexter Wong/Sam Wong. **Bert Baysa** and **Raj Mehta** were also runners-up in the Open Doubles Consolation A and **Young Paik/Walter Watt** were runners-up in the Novice Doubles Consolation A matches . . . We were happy to see that **Gene Wong** and **Jim Musgrave** were also runners-up in the Novice Doubles Consolation B matches . . . Thus it seems that though the dentists may have taken all the championship positions, we made a clean sweep of all the runners-up positions . . . (Sour grapes?)

### Turf Diggers . . .

We are able to report on two hole-in-oners . . . We only recently learned that **Dick Omura** made his hole-in-one on Dec. 11, a Sunday, on the 11th hole at Mid Pac CC using a No. 5 iron . . . **Ike Nadamoto**, playing with the Mid Pac Thursday Club holed-in-one the 11th hole in April.



The Annual DDD golf tournament was held at the Pearl Country Club and hosted by the dentists this year. **Thomas Ito** shot an overall low net of 63 with a 29 handicap. **Al Paraz** shot an 80-16 for a net 64 to win in B Flight. It's true, but unbelievable! **Bill Dang** did *not* win. He shot a 89-17 for a net 72 in B Flight which wasn't good enough.

The Annual Kaukini Golf Tournament was held at Waialae CC and the physician winners were two Ike's . . . **Ike Nadamoto** shot a net 67 and **Ike Kawasaki** was in 3rd place . . .

The Annual HMA Golf Tournament will be held on Oct. 11, a Wednesday, at the Leilehua Golf Course. The entry fees will be \$25.00 for both guest and member flights. Sportsman's Nite will cost \$20.00 and will be at the Kanraku Tea House, featuring a "Las Vegas Nite." Chairman, **Neal Wynn** and committee members **Tom Kobara, Bill Dang, Jim Navin, Richard Yoshino, Dan Lau** and **Henry Yokoyama** promise prizes for all . . .

**Garth Morimoto** who has had a long dry spell finally won the Mid Pac Thursday Club's December trophy . . .

### Other Sportsmen . . .

**George Kennesey** and **Dick Tessoro** were diving off Campbell Industrial Park on April 29, Sunday, and caught over 40 good sized lobsters in the rough surf. On that same day, **Roy Kaye** and his cohorts came down from the Molokai mountains with 4 good sized deer . . . (Reported by John Grant Riker representative)

**Fred Reppun** sent us this clipping from the Harvard Medical Alumni Bulletin: Sep-Oct. 78—"Class 1939: Under the Bulletins relentless questioning **James G. Bennet** (Our Kaiser pathologist) has been forced to overcome his modesty and admit that he did participate in this year's Boston Marathon . . . "I came to Boston, I ran and finished in 3 hrs. 29 minutes 3 seconds—one of 9 official entrants over age 60 who finished under 4 hours."

Even Kona has its Sunday morning runners. **Jeff McDevitt**, Kealahou GP, is medical consultant for the clinic. Jeff, who has been running for four years, says, "What we're pushing in this clinic is preventive medicine . . . "We're encouraging people to work up to running for a continuous hour three times a week at a very slow and enjoyable pace . . . Running longer than half an hour is the magic formula. This is what it takes to lower blood cholesterol and triglyceride levels, to lower blood pressure, and to lower the resting heart rate and most of the other risk factors for the degenerative diseases . . . I resisted running for quite a while because I was always one of the people that felt jogging was one of the most boring things you could do. Eventually, though, I had to face up to the fact that medical research has proved beyond a doubt that my sporting activities, like tennis and basketball, were second rate when it comes to preventive medicine . . . " Jeff has run in one Honolulu marathon but he doesn't push running races because competition destroys the psychological benefits if it is overdone.

## "Marriage and Other Mistakes" or "How to be Happy Though Married . . ."

from **Beverly Mead's** talk at the HCMS meeting at the Kahala Hilton on Apr 9)

"Being named 'Beverly' puts me in a sexually anonymous situation . . . Believe me, I like the name . . . though I've been accused of being a transvestite . . . and have been in very awkward situations such as being sent to summer camp and assigned to the girls camp across the lake, etc, etc. . . .

The world is getting complicated . . . and this is tough on marriages . . . so much so that everyone needs a personal psychiatrist nowadays (like my wife has) . . . I've personally had 20 happily married years . . . Not bad for out of 26 . . .

We all need a conjugal relationship, ie, a close *meaningful relationship* . . . and marriage provides this. We have a need to cling and to have a close fit (laughter) ie, a structural fit . . . When we suffer from a bad fit, then therapy is worth having

. . . We are really discussing emotional fit in marriage . . . so that we can get more out of marriage . . . We are discussing maintenance more than prevention . . . Yet on the other hand, if we stop marriages, we may not even have any problems . . .

Most poor marriages were bad from the beginning and were for the wrong reasons . . . I'm against early marriages, esp teen age marriages . . . If someone proposes a law that says you can't get married before age 21, I would support it . . . Also, no one should become a parent before age 25 . . .

Here are three bad reasons for getting married . . . 1) Youngster seeking instant transition into maturity, believing that life would then have meaning. They are using marriage as a right of passage into the mature world. 2) She has a family on the way . . . I don't like shot gun marriages . . . They are not creating a real home for the youngster. Today, this need not be so . . . Statistically 4 out of 5 such marriages break up . . . 3) They're in love . . . If that's the chief reason, then forget it . . . *Love is blind and marriage is the greatest eye opener in the world* . . . Love is not a source of deep thinking . . .

Deciding to get married is the greatest decision a person makes . . . Try to be as objective as you can be . . . Say to yourself, 'If I didn't love him, what would I think of this guy? Change in a person's personality is gradual and evolutionary . . . never sudden and revolutionary . . . So how can you judge? . . . Go see where he got his influence . . . If you want to see what kind of a husband he will make, go see how his father treats his mother . . . That's how he is going to treat you . . . And vice versa . . .

**Communication:** Done in different styles . . . Women are better talkers . . . In fact women on the average talk faster, oftener, and better than men . . . Besides, they enjoy talking . . . How many men would call up another guy on the phone just to chat . . . It is said women can't keep secrets . . . This is not true . . . They keep secrets just as well as men . . . But when the matter is not a secret, they are all too willing to share the information . . .

Back in 1928, there was a Dr. Woodlaw in Detroit. He was an OB Gyn specialist, a rarity in those days . . . He lived on Lake Sinclair and his only hobby was sailing . . . And that's all he talked about . . . A Friday afternoon lady's club invited him to talk about sex to their group . . . So he did, but neglected to tell his wife what his topic was . . . Next day, the club president met Mrs. Woodlaw in town and gushed, 'Your husband gave the most marvelous talk . . . ' 'I suppose he talked about his favorite subject.' 'Oh, we didn't know it was his favorite subject.' 'Oh yes, that's all he talks about.' 'Oh, is he such an expert?' 'You can't prove it by me . . . To tell you the truth, we only tried it twice. The first time, he got so terribly sick that he vomited and the second time, his hat blew off and he nearly fell off.'

**Subtle Communication:** When out of a clear blue sky, your wife says, 'I don't think he meant that at all,' you have no idea what she is talking about, but the correct reply is 'I think you are right.' Here's an example of subtle communication: The husband comes home tired and hungry . . . The wife plants a kiss and pauses . . . 'It's been such a long hard day,' she says . . . (What did she mean? She means that they should go out to dinner.) The husband sympathetically, 'I'm sorry you had such a hard day.' Wife says pleasantly, 'Dinner is not ready . . . What would you like for dinner?' 'Well, anything is fine . . . ' 'We don't have anything . . . ' 'That's all right, Honey. Go ahead and open up anything.' (The wife is seeking an extra dividend in the form of attention.) On the other hand, men are not so subtle . . . They are absolutely resolute and determined . . .

**Universal Neuroses of Men and Women:** Men tend to over rate and put extra value on competition . . . You gotta be successful . . . You gotta be successful . . . Women are inclined to be engrossed with receiving personal attention and with subtleties . . . She complains, 'He takes me for granted.' A husband would never say, 'She takes me for granted.' In fact that would be a beautiful compliment to him . . . How do we get this way . . . We help little boys and girls slip into these roles . . . A little boy, we teach to become aggressive . . . 'Let me feel those muscles.' 'How strong you are.' To a little girl, we say, 'What a pretty girl you are . . . ' We praise their dainti-

ness, their dress, etc, etc. This influences their sexual behavior . . . Thus the typical honeymoon situation . . . The groom has a need for showing his prowess and for conquering . . . He strides into the bedroom, ala naturel and expects her to acclaim, 'Possess me you Greek God!' Instead, she sits fully dressed and is thinking, 'He's not paying any attention to me . . . I'm not getting any special regard . . .' She can only get satisfaction when her need for attention is fulfilled . . .

In premarital counseling, a few pertinent questions should be asked . . . 1) Brides and grooms should ask, 'Which one of the in-laws will I have the most trouble with?' 'What am I going to do about it?' 'Where are we going to spend the next Xmas?' 'Which one of us is going to get up first in the morning?' 'What's for breakfast?' 'Who's going to carry out the garbage?' 'Does he have a night out with the boys?' 'When's your next honeymoon going to be?'

As physicians, you are obliged to ask during the premarital exam, 'Do you have any sex problems?' 'Nah! Doc, we've tried it already and there was no problem.' But you must keep the door open . . . So you say, 'If you ever seem to have a sex problem, come to see me . . . If I can't handle the situation, I'll send you to someone who can.'

**For the already-married couples . . .** Couples are supposedly structurally fit, ie, personality fit . . . Certain personality patterns tend to emerge . . . Even with sex differences, however, things should balance off to a happy blend . . . The basic differences are 1) Women are intuitive . . . Women tend to be more attentive and are better observers . . . On the other hand, men are not so observant and most of the time don't listen . . . Attentiveness is important to men . . . Women pick up innuendos (Italian word for suppositories) . . . Women are more observant and notice the slightest details, while men being poor listeners often get into difficulties . . .

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**Problems of Impulse:** In marriage counseling, I dread the statement, 'I'll never forget the time that . . .' Part of a successful marriage is to forget . . . We all inevitably make mistakes and we should not bring up such past mistakes . . .

I'm from Creighton and that's a Jesuit Institution . . . a couple came to confession . . . 'Father, we were going to give up sex for Lent and we held out till the middle of Holy Week . . . But then . . .' Priest sympathetically: 'You are forgiven . . . You should not make such rash vows in the future . . .' Husband with a sigh of relief, 'We were afraid you would throw us out of the church.' Priest: 'What made you think that?' Husband: 'Well, they sure threw us out of the supermarket in a hurry.'

With troubled couples, never advise them to have a baby as a solution . . . In marriage, we must all anticipate a period of adjustment . . . This happens with in-laws . . . For example, the wife says, 'My mother says you're effeminate.' The husband retorts, 'Well, compared to her I may be.'

**Problem About Money:** Women are accused of impulse buying. Yet with big items, men are more at fault . . . Women feel it is their birthright to return and exchange purchases . . . Women are more emotional than men . . . Ogden Nash once said, 'Women wore high heels and all their feelings spilled out.' Emotions are a safety valve . . . For example, when women act out a suicide, it becomes an emotional release . . . They feel better . . .

**Problem of Fighting in Marriage:** Fighting does not have to be part of an unhappy marriage . . . It can be constructive or destructive. You must have an understanding of certain ground rules: 1) Keep it verbal 2) Keep it private . . . You can fight in front of the kids . . . It may be good exposure for them 3) Keep it short and snappy . . . Never let it become a grudge match . . . And no pouting . . . 4) Let each party express his feelings . . . 5) Taboos: Don't attack a man's masculinity . . . Don't attack a woman's femininity . . .

**Identify in Marriage:** Don't lose your own identity in marriage . . . It's OK to assert one's identity . . . Gilbran on marriage: 'Let there be spaces in your togetherness.'

**Marriage Counseling:** You ask both the husband and the wife: 'Write down what you can do to make this marriage better . . . This is your homework . . .' Give them stickum tape so they can stick it up on their mirrors . . . Then there ensues positive thinking . . . Makes the person look at himself and he realizes he has to change his own responses . . . When he does, the wife also has to change . . . Don't look for blame . . . Be content with what you have . . .

**Physician's Nature:** Physicians are more compulsive . . . They focus on defeat . . . They tend to be hypercritical of themselves . . . Doctors should occasionally pat themselves on their backs . . . Whatever the size of the graduating medical class, there has to be someone at the bottom . . . And we have a special name for that man . . . We call him "Doctor" . . . Don't let physicians feel guilt . . . My wife's favorite trick is to point a finger at me and say, "You're doing it again."

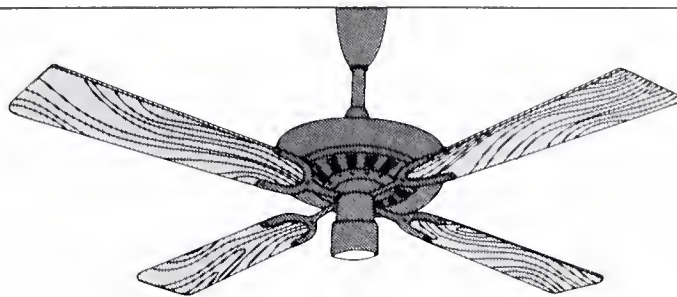
Love does not make marriage . . . Marriage is built on tolerance, trust, dedication and maturity . . .

**Physician Marriages:** Tend to be a little more stable than those of other professions because of 1) social pressures and 2) they occur after finishing medical school when they are more mature . . . The most popular time for physician divorces are when they are getting out of residency or when they are setting up practices . . .

## Potpourri

Our surfing ophthalmologist **Malcolm Ing** delivered his paper, "100 Consecutive Anterior Chamber Implants" at a May 11 meeting of the American Intra-ocular Lens Society in LA . . . **Ralph Cloward**, our peripatetic neurosurgeon, participated in the National Conference on Lumbar Spine at Rush Medical College, then will go to Oswestry, England where he will be visiting professor at the Institute Orthopaedica. He will then proceed to Gothenberg, Sweden to participate in the Lumbar Spine Society meeting, returning in June . . .





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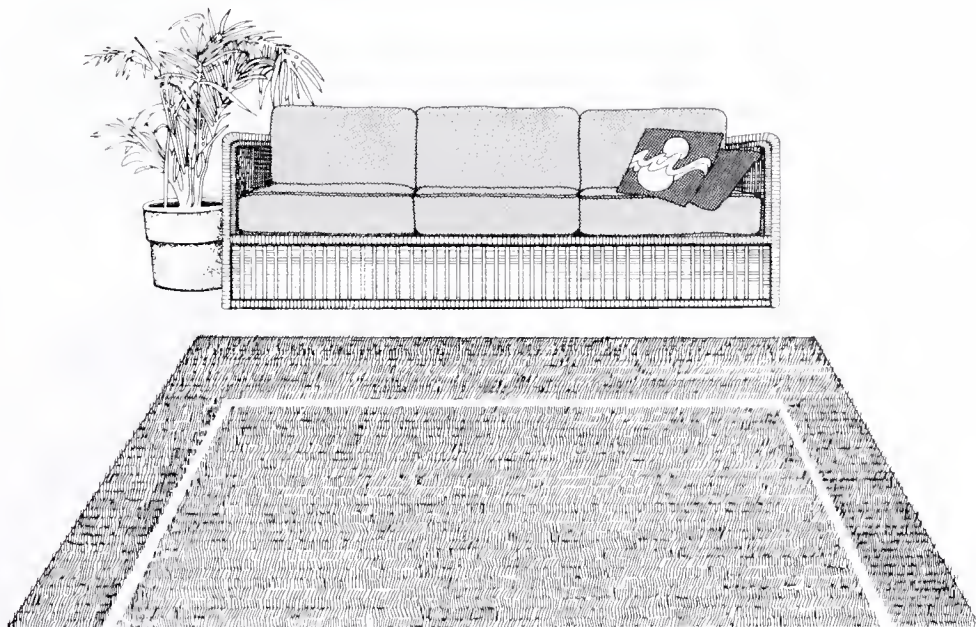
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The Physician's Exchange of Honolulu, Inc (an affiliate of the HCMS) is studying a 5-year contract with David Nattenberg (formerly with Radio Call) who has proposed a superior paging system with improved facilities, coverage, and servicing without added cost to the physicians . . . **Adele Koch**, present administrator, will be retiring as of June 30 this year and will leave for Florida where she plans to live . . . We'll miss her efficient administration . . . but HMA executive secretary **Jon Won** has found an equally efficient, personable, able person in **June Morioka** who presently runs the med assistant's program at KCC . . .

We attended the Ka Hana Ho'opuka (The Act of Emerging) ceremonies for the John Burns School of Medicine Class of '79 at Kennedy Theater and were enchanted by the deep baritone processional and recessional Hawaiian chants by **Dick Blaisdell** . . . **Charlie Judd** administered the Hippocratic Oath with his usual solemnity and sincerity and Dean **Terence Rogers**, who flew back from Washington for the occasion, was his usual good humored, witty self as he gave his "Perspectives" . . . Like father, like son: **Herbert K.W. Chinn**, who is taking up a urology residency in Dallas, Texas received a grateful handshake from dad, urologist **Herbert Chinn**. **Karl Chung**, another graduating senior, is going into pediatrics like father **Lindy Chun**. For other statistics, our professor of surgery, **Tom Whelan**, informed us while we milled around to meet the graduates, that **Clarice Sackett** was the daughter of Public Health Officer Sackett on the Big Island and that 30% of the graduating class were women . . . Somehow we get the impression that the med school graduates are looking younger and younger each year, or are we simply getting older?

Robert Slater, National MS Society medical programs director who was visiting the local chapter, reported that visna, a viral disease of sheep in Iceland, produces symptoms similar to human MS, viz attacks of paralysis and periods of remission, sometimes mild and other times severe. The theory is that when the sheep are in remission, the fragmented viruses

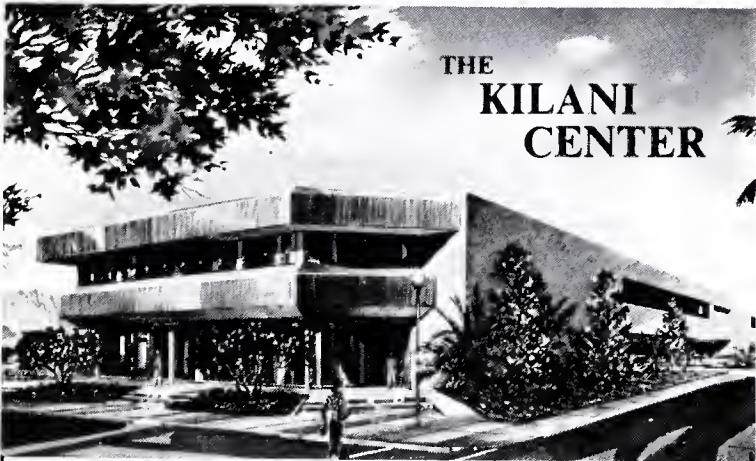
are preventing attacks and when an attack comes on, the whole viruses are present again. To date, no human virus has been directly implicated in MS, but it is conjectured that it may be a form of slow virus left over from some childhood viral infection like measles.

The ophthalmologists led by **John Corboy, O. P. Pinkerton, Robert Wong** et al sighed with relief when the bills permitting optometrists to use drugs to diagnose eye problems was killed in this legislative session . . .

Robert Irvine told the legislators that the 150-bed hospital being proposed for Hilo will not be able to meet the community's needs 10 years from now. He recommended that the new hospital be designed for easy expansion in the future and that equipment be leased rather than purchased. Robert also feels that there is lack of responsibility in the existing bureaucracy and that an easily identifiable group should be responsible. Sen Anson Chong suggested that the state hospital system be made semi-autonomous and Sen Neil Abercrombie feels that administration of hospitals should be contracted out.

**Fred Reppun**, in his role as chairman of the Kahaluu Neighborhood Board, has written to both Governor Ariyoshi, and Mayor Fasi to stop using herbicides to kill weeds along roads and highways, pointing out that herbicides are suspected of producing long term harmful effects . . . He also feels that killing the green weeds exposes litter and rubbish and that dry dead weeds are a fire hazard as well . . . Moreover, the roadside is drowned in poison which ultimately washes into Kaneohe Bay . . .

The Honolulu Medical Group has established a Department of Sports Medicine which is perhaps the first health service here to deal specifically with sports-related medical problems . . . **Alan C Nelson**, internist and preventive medicine specialist, will conduct free vegetarian cooking classes at Castle Hospital, starting with Spanish and Mexican cooking and then in Chinese cooking . . . **Richard You**, who has had a bit of rough going recently, had another setback recently when Federal Judge King refused to defer the sale of his building, the former York International Building . . . Richard is fighting to win back the building which he claims was sold below its appraised value and that the sale was the result of a conspiracy to defraud him and others . . . The DOH and the HMA have received complaints about a woman claiming to be from the county medical board who is conducting a telephone survey on family life, birth control and sex. The caller asks detailed personal questions . . . The HMA Annual Sports Medicine Symposium was held at McKinley High School on May 4 from 6:30 pm to 10:00 pm . . .



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**Our "Angels"**

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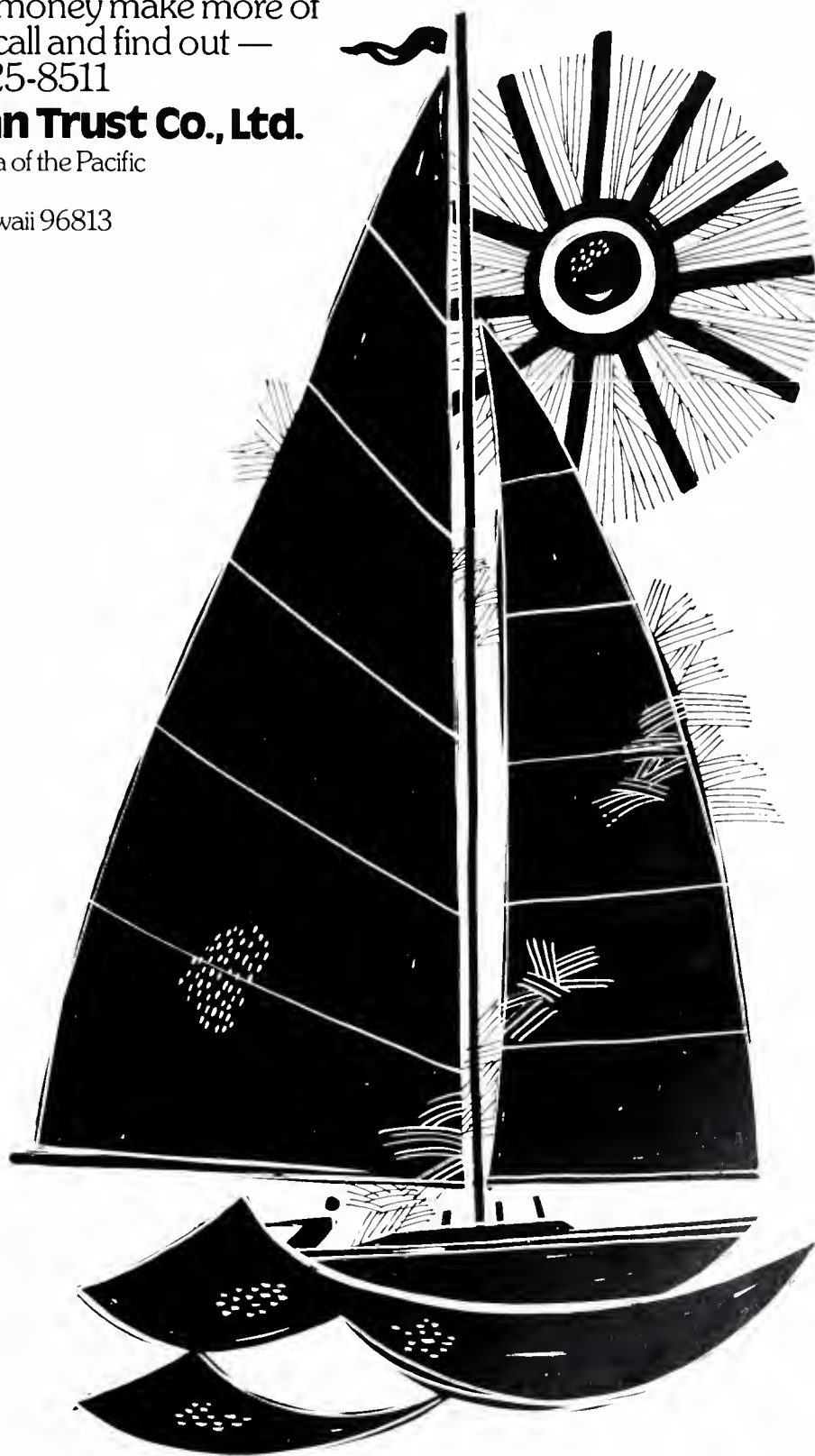
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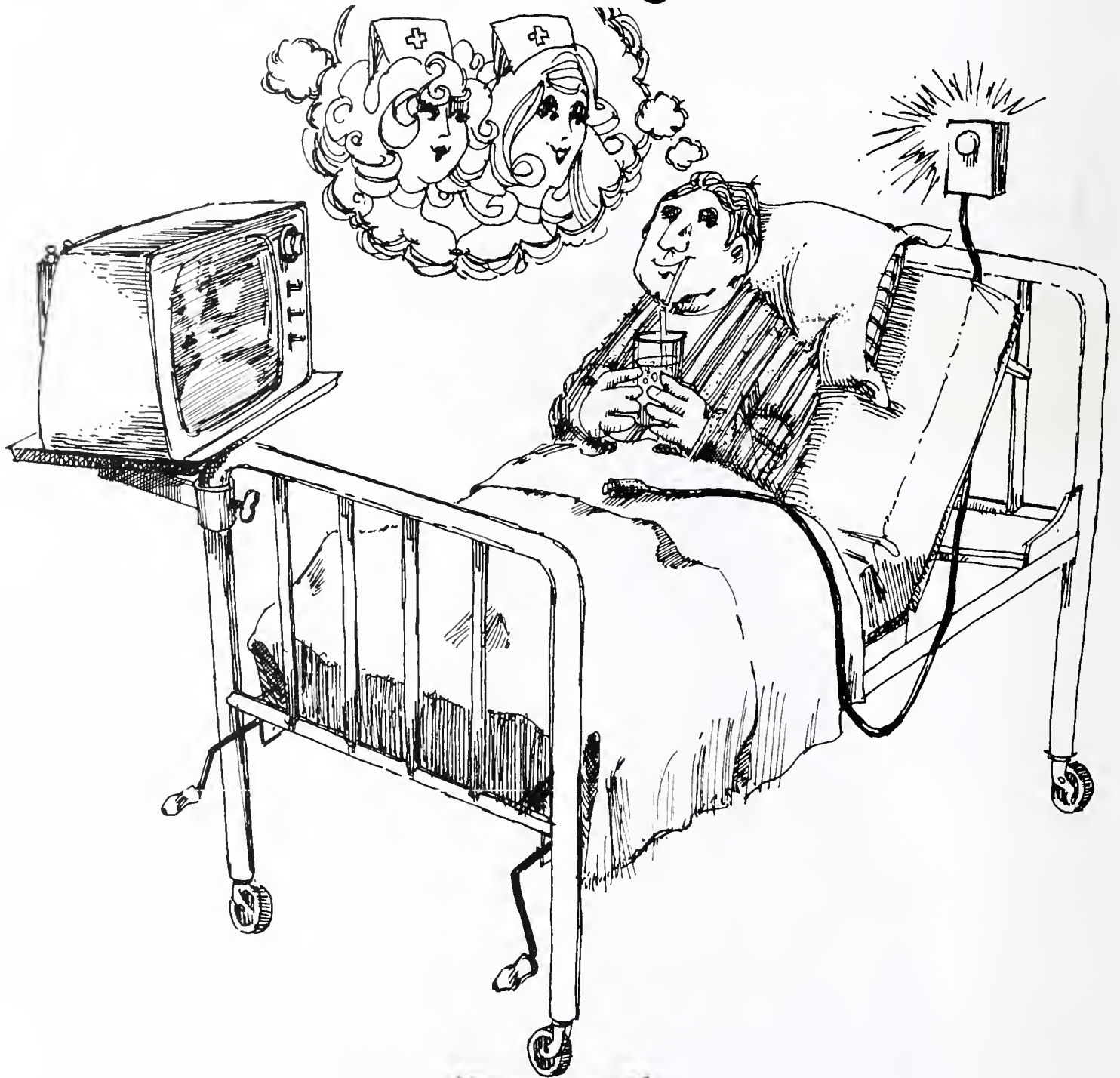
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JULY, 1979  
VOL. 38, NO. 7

# Hawaii Medical Journal

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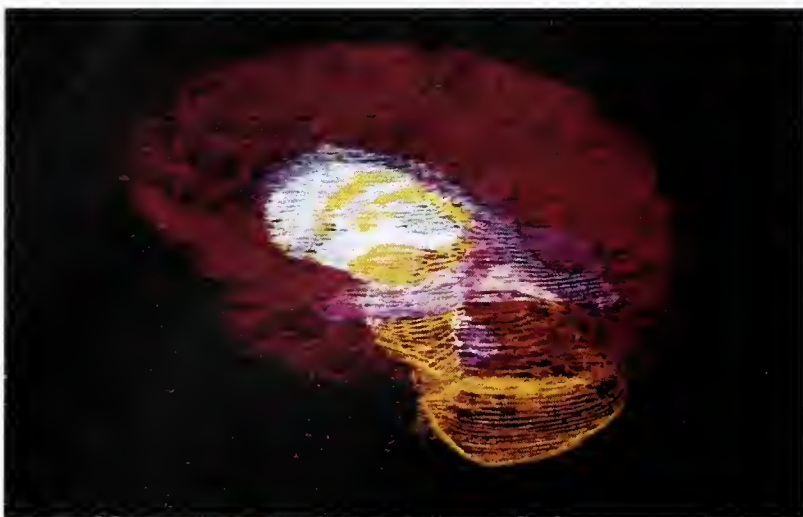
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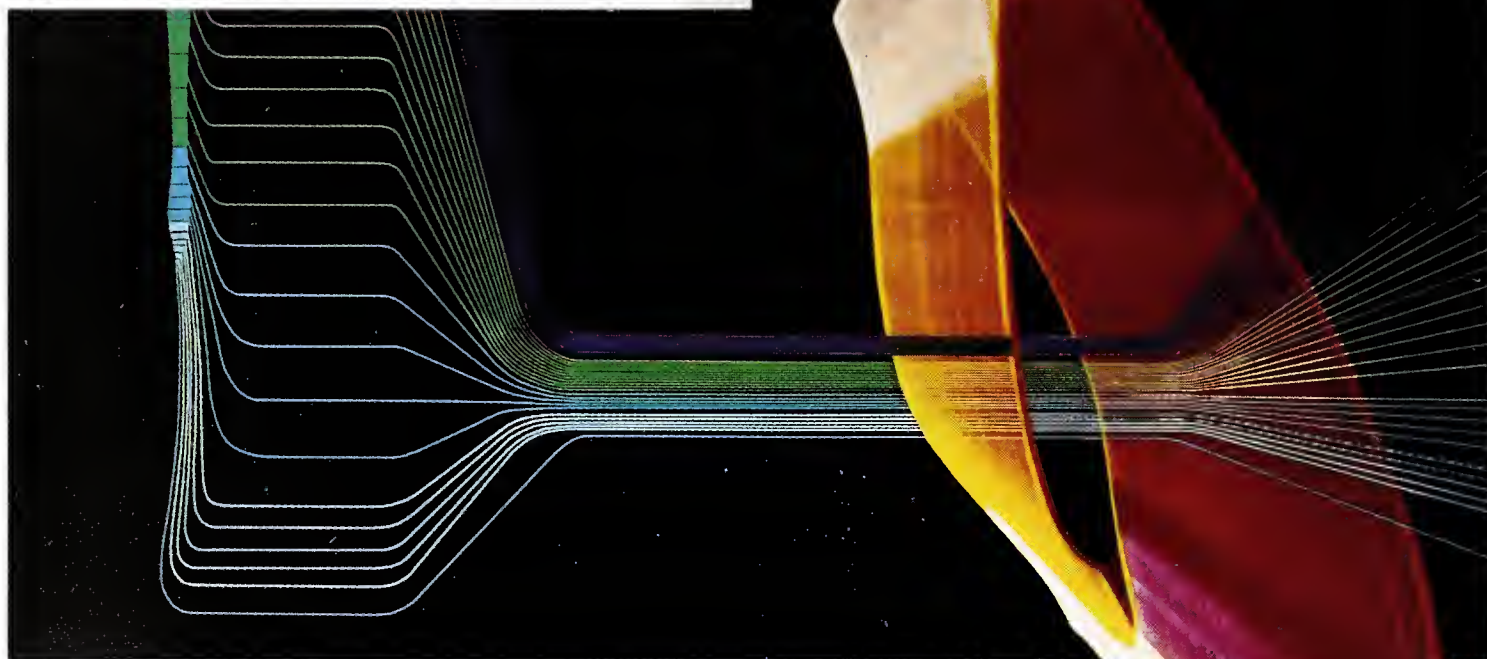
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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants

may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# The Maker

## Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



*MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.*

**FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were**

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

*MYTH: Industry favors only "expensive" brand names and denigrates all generics.*

**FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.**



# Matters.

**MYTH:** Generic options almost always exist.

**FACT:** About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

**MYTH:** Generic prescriptions are filled with expensive generics, thus saving consumers large sums of money.

**FACT:** Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

**MYTH:** Drugs account for a major portion of the rise in health care costs.

**FACT:** Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

**MYTH:** Government intrusions into the marketplace will save tax money.

**FACT:** Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

## The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

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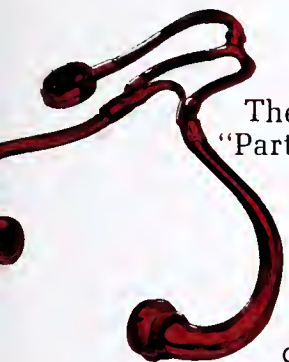
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# Remission of Idiopathic Nephrotic Syndrome In Three Oahu Children: A Four and One-Half Year Follow-Up

THERESIA G.H. TAN, M.D., ALEXANDER ROTH, M.D. *and*  
YI-CHUAN CHING, M.D., *Honolulu*

● *Idiopathic nephrotic syndrome intractable to steroid therapy constitutes a problem in pediatric practice. Immunosuppressive agents were, therefore, introduced in its treatment. Three patients, with steroid-dependent idiopathic nephrotic syndrome of 9-14 years' duration and showing numerous relapses, are presented. Complete remission of the disease was obtained only after chlorambucil was added to the prednisone therapy.*

The idiopathic nephrotic syndrome is characterized by proteinuria, hypoalbuminemia, hypercholesterolemia, and edema. Minimal changes in the glomeruli are seen on light microscopy, with fusion of epithelial foot-processes by electron microscopy.<sup>1,2</sup>

In the pre-steroid era, the mortality rate 5 years after diagnosis was 40 percent.<sup>3,4</sup> After steroids were introduced in 1951,<sup>5</sup> the death rate dropped to 6.5 percent.<sup>4</sup> Part of this improvement may have been due to the use of antibiotics. However, despite the beneficial effect of steroids in many patients, some 40 percent either showed no response or suffered numerous relapses.<sup>4,6</sup> These patients need repeated courses of steroids, which increases the many undesirable side effects of the drug. Moreover, the uncertainty of prognosis has significant psychological implications for the patient and his family.

Immunosuppressive agents were introduced in the treatment of intractable idiopathic nephrotic syndrome in 1963.<sup>7</sup> Among the drugs used were: azathioprine (Imuran),<sup>8</sup> 6-mercaptopurine (Purinethol),<sup>9</sup> nitrogen mustard (Mustargen),<sup>5,10</sup> and its derivatives such as cyclophosphamide (Cytosan)<sup>11,12</sup> and chlorambucil (Leukeran).<sup>13,14,15</sup> They were administered only to patients who are steroid resistant, or steroid dependent showing serious side effects, and who have frequently relapsing nephrosis.

Three patients of the latter group are presented in this paper. They displayed side effects of oral steroid therapy such as hypertension, growth suspension, Cushingoid appearance, and frequent infections. It should be emphasized that immunosuppressant agents were used only when it became obvious that these children could not be controlled adequately except by unacceptably high doses of prednisone.

## Case Reports

CASE 1. A 15-year-old Filipino girl had developed idiopathic nephrotic syndrome at the age of 18 months. She presented with edema of the face and lower extremities, and ascites. Her urine showed 3+ protein and some hyaline casts. Blood urea nitrogen was 6.9 mg percent and serum cholesterol was 183 mg percent. Total protein was 4.8 gm percent, albumin 1.3 gm percent, and globulin 3.5 gm percent. Urinary protein was 2 gm/24 hours. She was treated with 1-2 mg per kilogram body weight of prednisone per day, until the urine became protein-free.

Relapses had occurred whenever the prednisone was reduced below 0.5 mg/kg/day. The kidney function remained normal throughout the years. Beta 1-C globulin level was normal. A kidney biopsy showed no definite histopathologic abnormality.

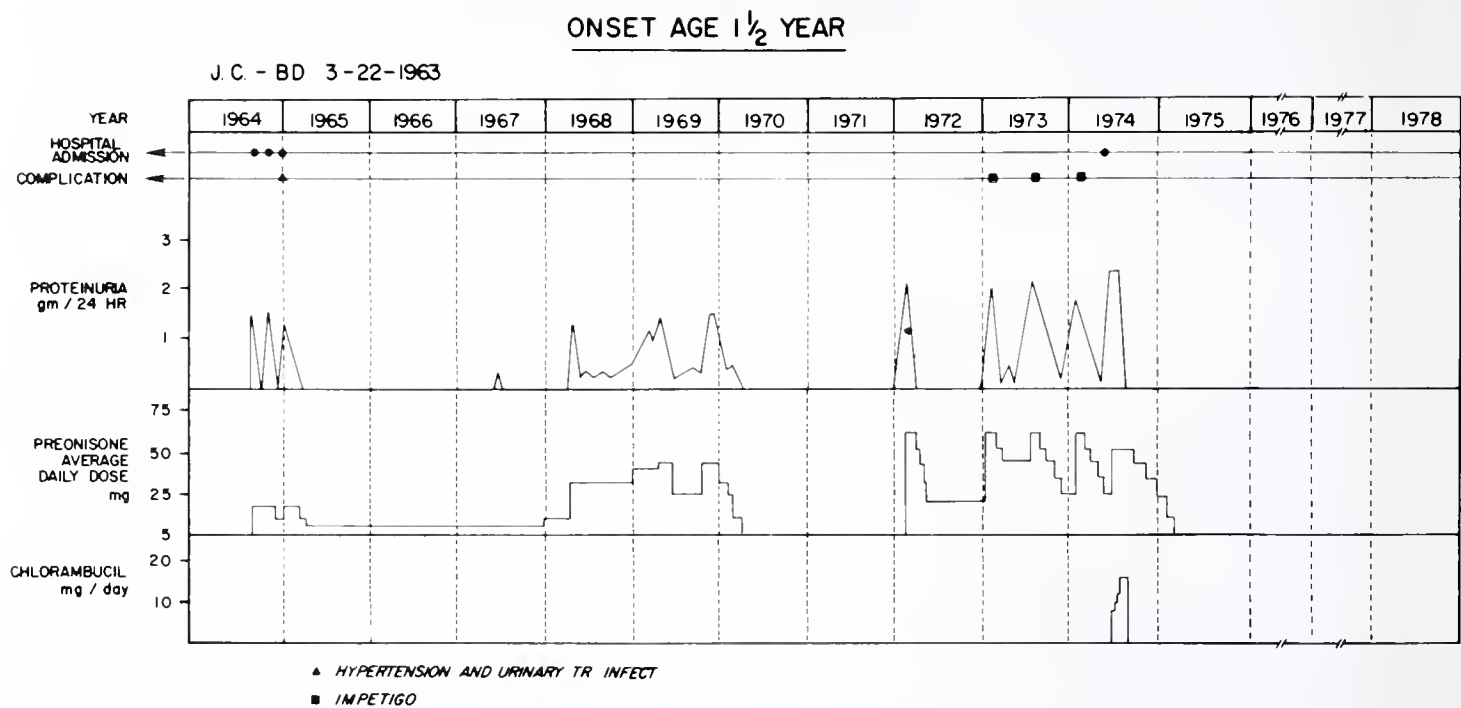
At the age of 7 years, she had a remission and was off medication for 1½ years. Prednisone therapy was resumed at 2-3 mg/kg/day every other day to keep her protein-free. On this dosage, she became cushingoid, suffered from frequent impetigo, and developed hypertension.

At this time, chlorambucil was started, in combination with 100 mg of prednisone, every other day. The starting dose of chlorambucil was 0.15 mg/kg/day in divided doses, and was increased by 2 mg every two weeks. Remission was

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FIG. 1.—Diagram of Patient No. 1.  
Clinical course of the nephrotic syndrome on steroids and chlorambucil

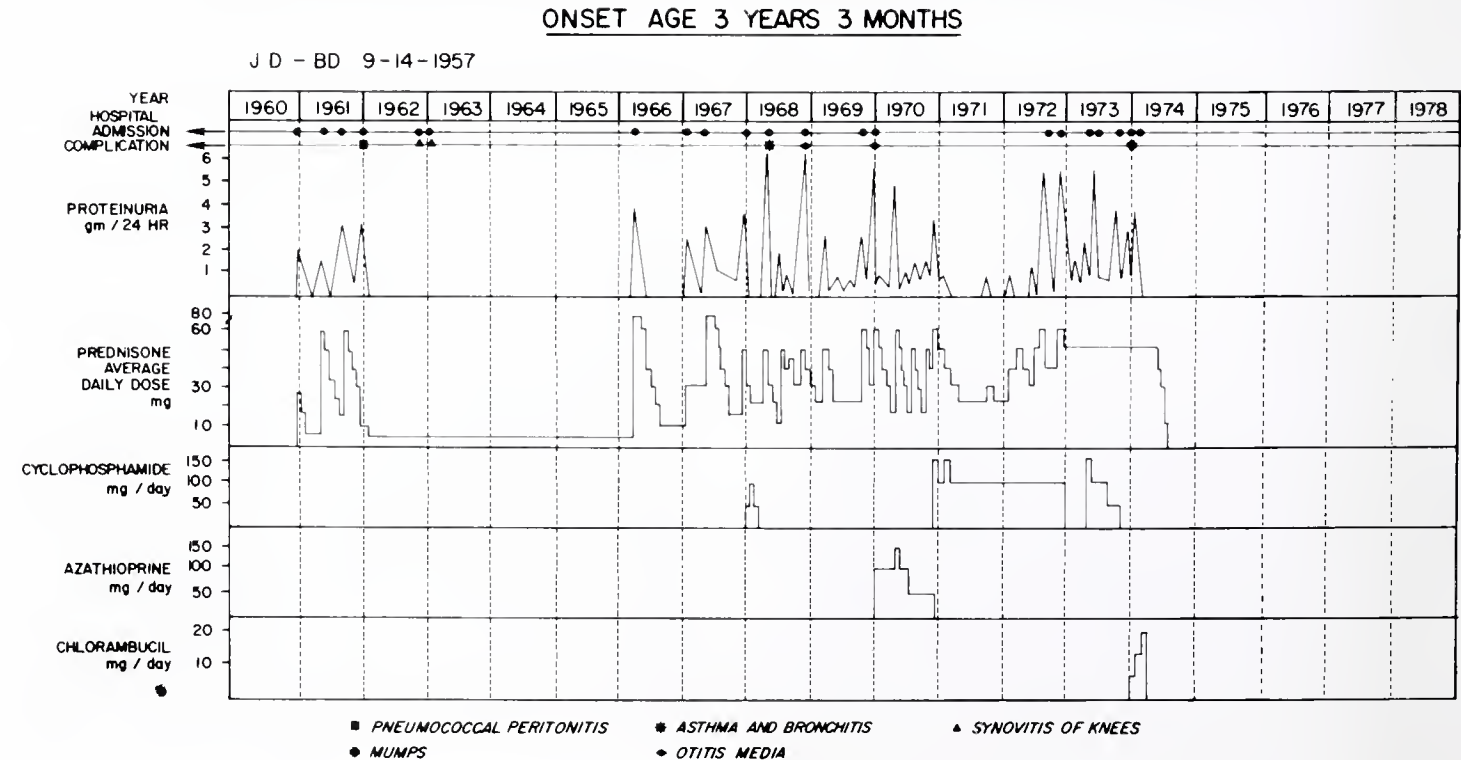


induced after 2 weeks. When the dosage of chlorambucil reached 0.32 mg/kg, it was discontinued because the white count dropped to 3,000/mm<sup>3</sup>. Prednisone was continued for another 6 months, during which time it was gradually tapered off. Weekly complete blood counts showed white blood cells ranging between 3,000-8,400/mm<sup>3</sup>, hemoglobin between 12.9-16.4 gm %, and amylase between 34-46 mg %. Platelet count was adequate throughout the treatment.

The patient has now been in remission without medication for the past 4 years.

CASE 2. A Hawaiian-Chinese-Portuguese boy developed idiopathic nephrotic syndrome at the age of 3 years, 3 months. He had generalized edema, 3+ proteinuria, total serum protein of 3.5 gm %, albumin of 1.27 gm %, globulin of 2.2 gm %, and cholesterol of 345 mg %. BUN was 11.5 mg %. Prednisone was begun at 2 mg/kg/day, and this led to a remission for several months. As steroids were reduced gradually to 5 mg/day, exacerbation of the disease occurred. Over the following 7 years, he had 31 relapses, accompanied by infections, such as pneumococcal peritonitis, otitis media, bronchitis, and

FIG. 2.—Diagram of Patient No. 2.  
Clinical course of the nephrotic syndrome on steroids, azathioprine, cyclophosphamide and chlorambucil





mumps, and had many hospitalizations. At 10 years of age, cyclophosphamide at 3 mg/kg caused a 10 month remission, but proteinuria recurred. A third course was of no further benefit.

Throughout his illness, his kidney function remained normal with BUN ranging between 12-24 mg %. Beta 1-C globulin was within normal limits. A kidney biopsy showed minimal changes by light microscopy.

At 17 years of age, he was treated with chlorambucil and prednisone. Chlorambucil was started at 0.15 mg/kg and increased 2 mg every week, until a dose of 0.438 mg/kg was reached. At this level, the hemoglobin dropped from 15.4 gm % to 10.6 gm %, and the hematocrit from 41.9% to 30.7%. Subsequently, his white blood cells dropped to 3300/mm<sup>3</sup>, and chlorambucil was stopped, but prednisone was continued until the blood count became normal again. Prednisone was tapered over a period of 5 months. The patient went into remission after 4 weeks of treatment, and he has been symptom-free without medication for 4½ years.

CASE 3. A 15-year-old Filipino boy was first seen at the age of 5 years with a history of nephrotic syndrome since the age of 1½ years. He had previously been cared for by another pediatrician, and had several hospitalizations elsewhere for his kidney disease. His mother related that he had never been totally off prednisone at any time, and that she regulated the dose herself without consultation with their pediatrician.

When he was first seen, he was cushingoid and in relapse. Laboratory studies revealed proteinuria of up to 6 gm/24 hours. The elec-

trophoresis of his urine protein showed a predominance of albumin. Total serum protein was 3.5 gm %, with albumin of 1.0 gm %, and globulin of 2.5 gm %. Serum cholesterol was 856 mg %, BUN 11 mg %, and beta 1-C globulin has always been in the normal range. A renal biopsy revealed minimal changes compatible with idiopathic nephrotic syndrome.

Altogether, this patient has had 11 hospitalizations related to his nephrotic syndrome and 18 relapses in the course of 6 years. During this period, he always responded to steroids, but proteinuria occurred when steroids were decreased to 5 mg daily. He was never hypertensive, except when on high doses of steroids to 60 mg/day, but his linear growth rate was markedly impaired.

At 7 years of age, cyclophosphamide was given at a dose of 5 mg/kg/day (100 mg daily). Reduction to 2.5 mg/kg/day was necessary when his white count dropped from 18,000 to 2,600/mm<sup>3</sup>. Since no satisfactory response was obtained after a 4-month course, the cyclophosphamide was discontinued.

Chlorambucil was begun at 11 years of age because of multiple exacerbations necessitating increasing dosage of prednisone, to induce remission, resulting in a marked cushingoid appearance. The initial dose was 0.1 mg/kg/day (2 mg/day), which was increased in a gradual step-wise fashion to a maximum of 0.6 mg/kg/day (18 mg daily), over a period of 20 weeks. He had, during this time, one grand mal seizure, diagnosed as idiopathic. He has been maintained on phenobarbital.

Remission was obtained 8 weeks after a com-

FIG. 3.—Diagram of Patient No. 3.

Clinical course of the nephrotic syndrome on steroids, cyclophosphamide and chlorambucil

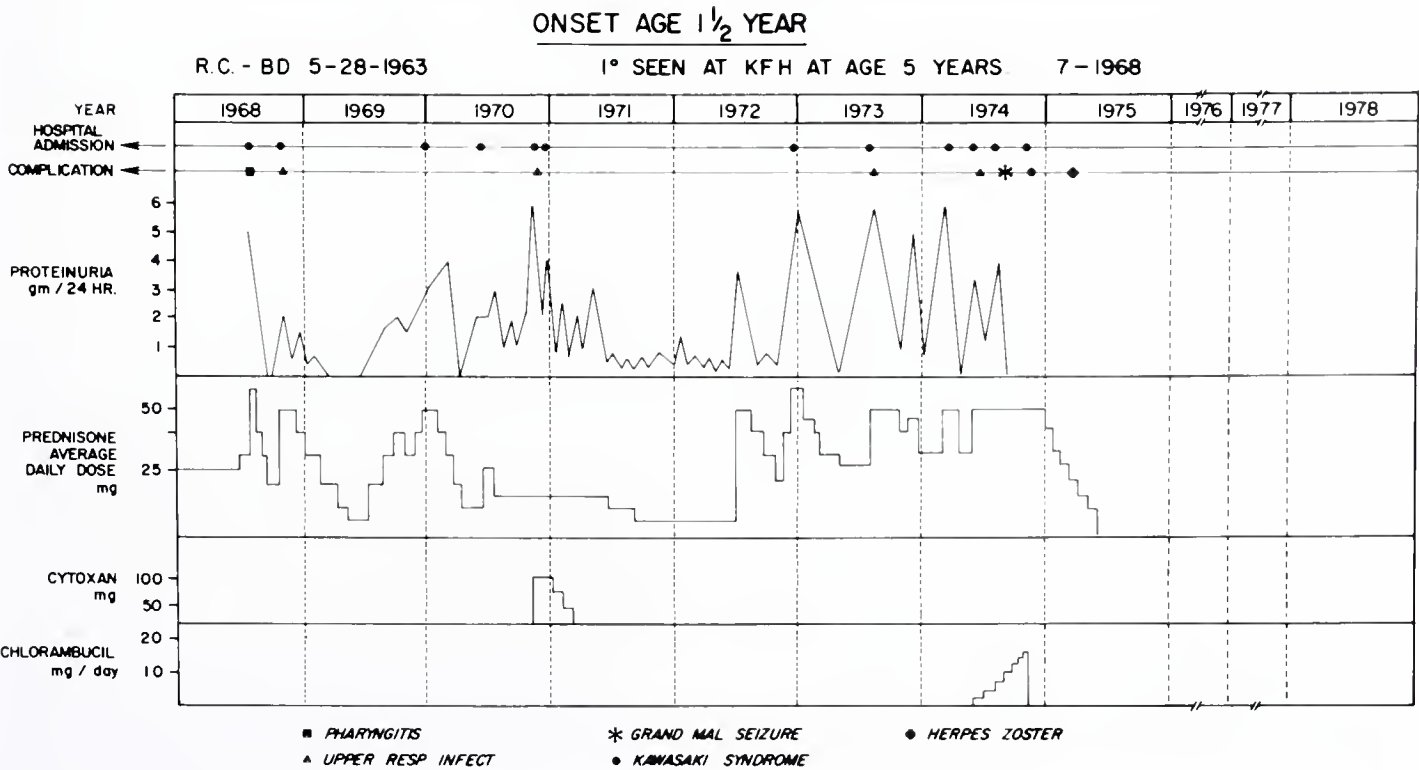


TABLE 1.—Summary of duration of disease, treatment and remission.

PATIENT	AGE OF ONSET AND SEX	DURATION OF DISEASE	TOTAL RELAPSES	DURATION STEROID R <sub>x</sub>	DURATION CHLORAMBUCIL R <sub>x</sub>	PERIOD OF REMISSION S MEDICATION	AGE PATIENT NOW YEARS
1. J. C.	F. 1½ YEAR	9 YEARS	14	7½ YEARS	8 WEEKS MAX. 0.32 mg/kg	4 YEARS	15
2. J. D.	M 3 YEARS + 3 MO.	14 YEARS	31	14 YEARS	13 WEEKS MAX 0.438 mg/kg	4½ YEARS	21
3. R. C.	M 1½ YEAR	10½ YEARS	18	10½ YEARS	20 WEEKS MAX 0.6 mg/kg	4½ YEARS	15

bined regimen of prednisone and chlorambucil. The latter agent was discontinued because the patient developed a fulminating Kawasaki syndrome and coincident bone marrow suppression of all cell lines, which was transitory. The prednisone was sustained and gradually decreased over a period of 6½ months after the chlorambucil was discontinued.

The patient has remained in remission for 4½ years.

### Discussion

The prolonged use of oral prednisone in our patients lead to the development of complications such as hypertension, cushingoid appearance, growth suppression, and infections, including peritonitis and synovitis, frequent impetigo, and bronchitis. The steroids did not prevent the development of bronchial asthma in Patient No. 2 (Fig. 2), nor did it prevent frequent eczematous skin rashes in Patient No. 1 (Fig. 1).

Since our 3 patients fulfilled the criteria of steroid resistance and steroid dependence, and have developed side-effects of this medication,<sup>16,17,18</sup> the use of chemotherapeutic agents was considered.

Despite several reports of the beneficial effects of cyclophosphamides<sup>9,19,20</sup> in steroid-dependent cases of nephrotic syndrome, this drug failed to produce a long-term remission in the 2 cases in which it was tried. Side-effects, such as alopecia or hemorrhagic cystitis, were not seen, but leukopenia to 2,000/mm<sup>3</sup> in Patient No. 3 led to discontinuation of the medicine.

The use of chlorambucil was reported by Lagrue et al in 1967,<sup>9</sup> by Grupe in 1973<sup>13</sup> and 1976,<sup>14</sup> and by Baluarte in 1978.<sup>15</sup> In the treatment of our patients, we have followed the regimen outlined by Dr. Grupe.<sup>13</sup>

The maximum dose given to Patient No. 1 was 0.32 mg/kg, at which level the white count

dropped to 3,000/mm.<sup>3</sup> In Patient No. 2, the maximum dose of chlorambucil that caused a decline in the hemoglobin and hematocrit, with subsequent leukopenia, was 0.438 mg/kg, whereas 0.6 mg/kg was tolerated by Patient No. 3. This dose was far above the regular dose of 0.4 mg/kg given to patients with neoplastic disease.<sup>21,22</sup>

In all 3 patients, the changes in the blood picture were only transient. This appears to be due to the protective effect of prednisone,<sup>13</sup> which was maintained at the starting dose of 2 mg/kg every other day, after the chlorambucil was discontinued.

On more than one occasion, these patients and their families were fully informed about the potential risks of sterility, oncogenesis, increased susceptibility to infection, alopecia, etc., which can accompany the use of chlorambucil.

So far our patients have shown no signs of gonadal dysfunction, a common complication in patients receiving cyclophosphamide or chlorambucil.<sup>11,12,22,23</sup> Patient No. 1 had menarche 6 months before chlorambucil was started. She then did not menstruate for 9 months after all medication was discontinued. The periods thereafter returned regularly. Secondary sex characteristics have developed normally in all 3 patients.

Although a definite conclusion about the beneficial effects of chlorambucil cannot be made on our small number of patients, our experience confirms the encouraging results of Grupe<sup>13</sup> and others.<sup>15</sup>

However, treatment with chlorambucil ought to be restricted to children in whom steroid therapy cannot be discontinued and is a danger in itself. Patients in whom the repeated use of steroids is not a threat probably should not be given chlorambucil until more is known about the dose response, and long-term side-effects better understood.

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*Prevalence related to life style*

# Diabetes in Hawaii: Arthritis/Rheumatism and Gout in Hawaii: Some Statistical Analyses

JOYCE M. VARNEY, M.S.P.H. and MILES M. SATO, M.S.P.H., *Honolulu*

Data used in these studies were provided by the Health Surveillance Unit of the Hawaii State Department of Health, and were derived from the Hawaii Health Survey for the period, 1974 through 1976.

Information for these surveys was collected by means of interviews conducted by trained interviewers using a standardized interview ques-

tionnaire. The respondents were all adult members from each selected household who were at home at the time of the interview. Information regarding members not present was provided by one of the adult members present.

## Methods

Households were selected by means of a statewide multi-stage cluster sample design. Three stages were used to select the sample. The first stage consisted of the selection of a sample of the total number of 1970 U.S. Enumeration Districts (ED's) in Hawaii. The probability of any ED being selected was proportional to the number of

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households in that ED. Since it was desired to select clusters of approximately 50 households, each ED was given what was called a measure. A measure was equal to the number of households divided by 50. The measures for each selected ED were cumulated, and a sample of ED's was further selected systematically at the rate of one in 13 measures. ED's with a measure value greater than 13 had a greater chance of being selected more than once.

The second stage of the sampling process was the selection of smaller areas within each of the selected ED's. These smaller areas were referred to as segments. The number of segments apportioned from each ED equaled the value of the measure for that ED.

The last stage in the sampling scheme was the selection of a sub-sample of households from within each of the selected segments.

Three types of errors are possible with this survey method. The first is a possible distortion of the population values estimated from the sample results. Since the primary sampling units (ED's) were selected proportionately to the number of households within them, ED's with relatively few households would have less chance of being selected. Therefore, if for some reason high concentrations of people with specific traits resided in those areas, the population estimates of the traits may be under representations of true population values.

The second possible error with this type of survey involves respondent error. Since it is possible that information was not always obtained from the person in question but from another household member, the reliability of that information may be a function of the accuracy of a second hand informant. The third possible source of error is that medical verification of the presence of the disease being studied was not obtainable, making the estimation of the true prevalence of arthritis and gout subject to errors

of subjective interpretation on the part of the respondents.

The race of each person's parents was asked. Persons of mixed racial parentage were included in "Other" unless either parent was Hawaiian or part-Hawaiian, in which case the individual was classified as Hawaiian. "Other" consisted of persons of mixed ethnic parentage other than part-Hawaiian, namely Samoans, other Pacific islanders, Koreans, Asians, Negroes, etc.

Diabetes

● Data concerning the prevalence of diabetes in the State of Hawaii are presented in this report. Associations of various social and demographic variables and diabetes were investigated. Variables studied were geographic location, age, ethnicity, marital status, and income level.

Data on the prevalence of diabetes in Hawaii are presented in the form of cross-tabulation tables in which cells contain estimates of the number of persons affected with diabetes among 1,000 persons who are members of that particular cross-tabulation cell.

The presence of diabetes varies considerably by age, sex, and ethnic status. Standardization procedures used in this report control further effects of the underlying population differences that may influence the results shown in the accompanying figures and tables.

For example, in Table 3, prevalence of diabetes per 1,000 persons by sex and age is shown. In this table the possible underlying effects of

TABLE 1.—Prevalence of diabetes by location: Hawaii, 1974-1976

STATE OF HAWAII	URBAN HONOLULU	ISLAND OF OAHU	HAWAII COUNTY	MAUI COUNTY	KAUAI COUNTY
19,219	8,528	14,788	1,936	1,438	1,057

TABLE 2.—Prevalence of diabetes per 1,000 persons by sex, age and ethnicity: Hawaii, 1974-1976

SEX	AGE	CAUCASIAN	CHINESE	FILIPINO	"HAWAIIAN"	JAPANESE	OTHER	TOTAL
MEN	<6	—	—	—	—	—	—	—
	6-16	—	—	2	—	—	—	—
	17-44	5	10	13	16	10	10	10
	45-64	39	93	47	104	75	55	65
	>64	66	88	75	99	109	148	90
	Total	13	45	25	20	36	12	23
WOMEN	<6	—	—	—	—	—	—	—
	6-16	4	—	2	2	1	1	2
	17-44	8	6	7	23	13	12	12
	45-64	31	40	53	77	64	98	57
	>64	81	107	106	134	115	189	109
	Total	15	28	18	22	37	18	24



differences in prevalence rates due to ethnic variations have been controlled.

Similarly, in Table 4, prevalence rates of diabetes per 1,000 persons by sex and ethnicity is shown. In this table, the underlying effects of age differences among the various ethnic groups have been adjusted so that meaningful comparisons can be made among the ethnic group.

Results

Diabetes was most abundant on the island of Oahu (Table 1). Table 2 shows that both males and females are equally affected by diabetes, but persons over age 45 appear to be much more likely to develop this disease (Table 3). Among the various ethnic groups in Hawaii, diabetes appears to be more common among persons of Hawaiian extraction (Table 4).

Geographic location appears to be related to the frequency of diabetes, but only for women (Table 5). There is a higher rate of diabetes among women on Hawaii and Kauai.

The frequency of diabetes occurrence also appears to be related to income level but again, only among women. Table 6 shows that women with lower family income levels are more apt to have diabetes than are those in higher family income levels.

TABLE 4.—Age adjusted prevalence of diabetes per 1,000 persons by sex and ethnicity: Hawaii, 1974-1976

ETHNICITY	MEN	WOMEN
Caucasian	13	15
Chinese	27	17
Filipino	19	20
"Hawaiian"	32	34
Japanese	24	25
Other	23	35

TABLE 5.—Age and ethnicity adjusted prevalence of diabetes per 1,000 persons by sex and location: Hawaii, 1974-1976

LOCATION	MEN	WOMEN
Urban Honolulu	29	26
Island of Oahu	28	27
Hawaii County	22	42
Maui County	24	36
Kauai County	28	42

TABLE 8.—Amount of Activity Limitation in persons with diabetes by ethnicity: Hawaii, 1974-1976

ETHNICITY	ACTIVITY LIMITATION				TOTAL WITH LIMITATION	TOTAL
	NONE	MINOR	MODERATE	SEVERE		
Caucasian	2,981 94.4%	66 2.0%	67 2.1%	43 1.4%	176 5.6%	3,157
Chinese	1,232 98.2%	22 1.8%	0	0	22 1.8%	1,254
Filipino	2,005 96.2%	0	22 1.1%	58 2.8%	80 3.8%	2,085
"Hawaiian"	2,877 46.7%	133 2.2%	131 2.1%	22 0.4%	286 4.6%	3,163
Japanese	7,712 97.1%	81 1.0%	87 1.1%	64 0.8%	232 2.9%	7,944
Other	1,551 96.0%	43 2.7%	22 1.4%	0	65 4.0%	1,616
Total	18,358 96.5%	345 1.8%	529 2.8%	187 1.0%	861 4.5%	19,219

An interesting result can be seen in Table 7. Apparently being widowed is associated with a higher frequency of diabetes. Perhaps further investigation into this phenomenon may yield interesting results; on the other hand, it may reveal that the results seen in Table 7 are artifactual, in the sense that the adjustment procedure did not adequately control for age and ethnic effects.

Table 8 shows that there are ethnic associations with the perception of varying levels of disability cause by diabetes. Filipinos appear to perceive diabetes as having a detrimental effect, whereas people of Hawaiian extraction perceive diabetes to have less effect on their daily activities.

Conclusions

From the results presented above, increased frequency of diabetes appears to be associated with age over 45, Hawaiian ethnicity, residing in a rural area, and, if a woman, coming from a lower income family.

It also appears that ethnicity is associated with the degree of perceived disability caused by being diabetic.

TABLE 6.—Age and ethnicity adjusted prevalence of diabetes per 1,000 persons by sex and family income level: Hawaii, 1974-1976

FAMILY INCOME	MEN	WOMEN
<\$5,000	35	67
\$5,000-\$9,999	39	44
\$10,000-\$14,999	39	39
\$15,000-\$19,999	39	34
\$20,000-\$24,999	28	25
>\$24,999	40	25

TABLE 7.—Age and ethnicity adjusted prevalence of diabetes per 1,000 persons by sex and marital status: Hawaii, 1974-1976

MARITAL STATUS	MEN	WOMEN
Never Married	29	19
Married	42	33
Widowed	95	57
Divorced	47	21
Separated	60	25

# Arthritis and Gout

● *Data concerning the prevalence of the chronic diseases, arthritis or rheumatism (henceforth referred to as arthritis) and gout in the State of Hawaii are presented. Associations between various social and demographic variables and these diseases were investigated. Studies were conducted to show how the presence of arthritis and gout in individuals relates to their geographic location, age, ethnicity, marital status and income level.*

Data on the prevalence of arthritis and gout in Hawaii are presented in the form of cross-tabulation tables in which cells contain estimates of the number of persons affected with arthritis or gout out of 1,000 persons who are members of that particular cross-tabulation cell.

The prevalence of arthritis and gout varies considerably by age, sex, and ethnic status. Standardization procedures used in this report control further effects of the underlying population

differences that may influence the results shown in the accompanying figures and tables. For example, in Table 5, prevalence of arthritis per 1,000 persons by sex and age is shown. In this table the possible underlying effects of differences in prevalence rates due to ethnic variations have been controlled.

Similarly, in Table 7, prevalence rates of arthritis per 1,000 persons by sex and ethnicity is shown. In this table the underlying effects of age differences among the various ethnic groups have been adjusted so that meaningful comparisons can be made among the ethnic groups.

## Results

The number of persons with arthritis and gout is highest on the island of Oahu (Tables 1 and 2). However, the age/ethnicity-adjusted prevalence rates of arthritis per 1,000 individuals

TABLE 1.—Prevalence of ARTHRITIS by location: Hawaii, 1974-1976

STATE OF HAWAII	URBAN HONOLULU	ISLAND OF OAHU	HAWAII COUNTY	MAUI COUNTY	KAUAI COUNTY
21,181	9,536	15,985	2,636	1,450	1,110

TABLE 2.—Prevalence of GOUT by location: Hawaii, 1974-1976

STATE OF HAWAII	URBAN HONOLULU	ISLAND OF OAHU	HAWAII COUNTY	MAUI COUNTY	KAUAI COUNTY
10,226	4,168	7,448	1,072	911	794

TABLE 3.—Prevalence of ARTHRITIS per 1,000 persons by sex, age and ethnicity: Hawaii, 1974-1976

SEX	AGE	CAUCASIAN	CHINESE	FILIPINO	"HAWAIIAN"	JAPANESE	OTHER	TOTAL
MEN	<6	—	—	—	—	—	—	—
	6-16	—	—	—	1	—	1	1
	17-44	8	6	5	7	4	10	7
	45-64	47	32	42	40	23	46	35
	>64	42	71	73	198	60	189	88
	Total	18	22	21	12	14	12	16
WOMEN	<6	—	—	—	3	—	—	1
	6-16	4	—	—	2	3	4	2
	17-44	24	6	10	18	9	4	15
	45-64	145	68	42	77	61	112	84
	>64	310	164	113	200	129	233	192
	Total	58	43	17	23	36	10	36

TABLE 4.—Prevalence of GOUT per 1,000 persons by sex, age and ethnicity: Hawaii, 1974-1976

SEX	AGE	CAUCASIAN	CHINESE	FILIPINO	"HAWAIIAN"	JAPANESE	OTHER	TOTAL
MEN	<6	—	—	—	—	4	—	—
	6-16	—	—	—	—	—	—	—
	17-44	6	19	20	16	12	10	12
	45-64	39	98	67	77	59	53	59
	>64	59	82	72	84	25	17	53
	Total	13	49	32	16	25	9	20
WOMEN	<6	—	—	—	—	—	—	—
	6-16	—	—	—	—	—	—	—
	17-44	—	—	2	4	2	—	1
	45-64	18	21	27	15	9	23	15
	>64	12	10	48	39	13	19	18
	Total	4	7	8	4	5	3	5



were greater on the islands of Hawaii and Kauai than on Maui and Oahu. Gout is most abundant on the island of Kauai (Tables 9 and 10). Tables 3 and 4 show that arthritis is more common among women, whereas gout is more often found in men. For each of the chronic diseases studied, prevalence increased geometrically as age increased (Tables 5 and 6). In terms of ethnic susceptibility (Tables 7 and 8), Caucasians and people of Hawaiian extraction appeared to be more susceptible to arthritis than did Asians. On the other hand, male Chinese, Filipinos and "Hawaiians" had a higher frequency of gout than did Caucasians.

Arthritis was more common among women in Hawaii and Kauai counties; however, it was also common among men in Hawaii county (Table 9). Table 10 shows that with respect to gout, both men and women in Kauai county had higher rates than any other island.

Lower income levels appeared to be associated with higher prevalence for each of the diseases studied among women, but not among men (Tables 11 and 12). Higher rates of arthritis were found among divorced men, and widowed or separated women (Table 13). Table 14 shows that only widowed and divorced men had higher prevalences of gout.

TABLE 5.—Ethnicity adjusted prevalence of ARTHRITIS per 1,000 persons by sex and age: Hawaii, 1974-1976

AGE	MEN	WOMEN
<6	—	1
6-16	1	2
17-44	8	14
45-64	41	94
>64	129	214

TABLE 6.—Ethnicity adjusted prevalence of GOUT per 1,000 persons by sex and age: Hawaii, 1974-1976

AGE	MEN	WOMEN
<6	1	—
6-16	—	—
17-44	12	2
45-64	60	18
>64	54	26

TABLE 7.—Age adjusted prevalence of ARTHRITIS per 1,000 persons by sex and ethnicity: Hawaii, 1974-1976

ETHNICITY	MEN	WOMEN
Caucasian	18	58
Chinese	13	25
Filipino	14	20
"Hawaiian"	21	36
Japanese	9	24
Other	23	36

TABLE 8.—Age adjusted prevalence of GOUT per 1,000 persons by sex and ethnicity: Hawaii, 1974-1976

ETHNICITY	MEN	WOMEN
Caucasian	13	4
Chinese	32	4
Filipino	26	9
"Hawaiian"	26	7
Japanese	19	3
Other	16	5

TABLE 9.—Age and ethnicity adjusted prevalence of ARTHRITIS per 1,000 persons by sex and location: Hawaii, 1974-1976

LOCATION	MEN	WOMEN
Urban Honolulu	17	45
Island of Oahu	17	45
Hawaii County	29	62
Maui County	17	17
Kauai County	16	66

TABLE 10.—Age and ethnicity adjusted prevalence of GOUT per 1,000 persons by sex and location: Hawaii, 1974-1976

LOCATION	MEN	WOMEN
Urban Honolulu	23	5
Island of Oahu	24	6
Hawaii County	27	7
Maui County	28	9
Kauai County	52	14

TABLE 11.—Age and ethnicity adjusted prevalence of ARTHRITIS per 1,000 persons by sex and family income level: Hawaii, 1974-1976

FAMILY INCOME	MEN	WOMEN
<\$5,000	38	114
\$5,000-\$9,999	31	71
\$10,000-\$14,999	27	90
\$15,000-\$19,999	36	62
\$20,000-\$24,999	38	54
>\$24,999	14	65

TABLE 12.—Age and ethnicity adjusted prevalence of GOUT per 1,000 persons by sex and family income level: Hawaii, 1974-1976

FAMILY INCOME	MEN	WOMEN
<\$5,000	26	11
\$5,000-\$9,999	33	9
\$10,000-\$14,999	32	9
\$15,000-\$19,999	30	3
\$20,000-\$24,999	28	3
>\$24,999	17	7

TABLE 13.—Age and ethnicity adjusted prevalence of ARTHRITIS per 1,000 persons by sex and marital status: Hawaii, 1974-1976

MARITAL STATUS	MEN	WOMEN
Never Married	21	38
Married	26	47
Widowed	25	83
Divorced	49	49
Separated	11	92

TABLE 14.—Age and ethnicity adjusted prevalence of GOUT per 1,000 persons by sex and marital status: Hawaii, 1974-1976

MARITAL STATUS	MEN	WOMEN
Never Married	30	3
Married	37	8
Widowed	72	6
Divorced	52	5
Separated	42	—

Summary

These data show important relationships between the demographic and social factors studied and the frequency of arthritis and gout, and of diabetes, among the people of Hawaii.

Acknowledgments

We acknowledge the cooperation and technical assistance of Thomas A. Burch, M.D., MPH; Chief, Research and Statistics Office, Hawaii State Department of Health; and of Blair Bennett, Ph.D., of the University of Hawaii School of Public Health.



## Voluntary Success or Federal Excess

As a Presidential non-hopeful, comedian Pat Paulsen vowed that he could lick inflation—and would spend “any amount of money it takes.”

In a far grimmer vein, we similarly could ask: How much of the people’s money would the federal government spend to save them money on hospital bills? To what degree would the cost of implementing the Administration’s hospital cost-containment proposal offset any savings that might result?

Those are questions that members of Congress (and their constituents) should wonder about as that piece of legislation locomotes toward possible enactment, as a sword of Damocles over our Voluntary Effort.

The measure at this stage is too amorphous to allow an estimate of its implementive cost. Also, HEW Secretary Califano has minimized the red-tape threat, asserting that just one additional line in a present form would suffice.

However, as the American Hospital Association notes:

- It would take at least a year to promulgate regulations occasioned by the bill—and time is money.
- A sophisticated staff would be needed to process exemptions requested under the bill.
- Such a staff would also be needed to compute hospital spending in the nation at large, in each non-exempt state, and in hospitals therein.

We can adapt to this situation a statement by Attorney General Griffin Bell:

“Each incremental cost added to a product or service by a new and perhaps unnecessary regulation further erodes the buying power of the American dollar.”

According to AMA testimony in Congress, the regulatory process already “has added tens of

billions of dollars to the cost of medical care” and “may lead to the rationing of health care.”

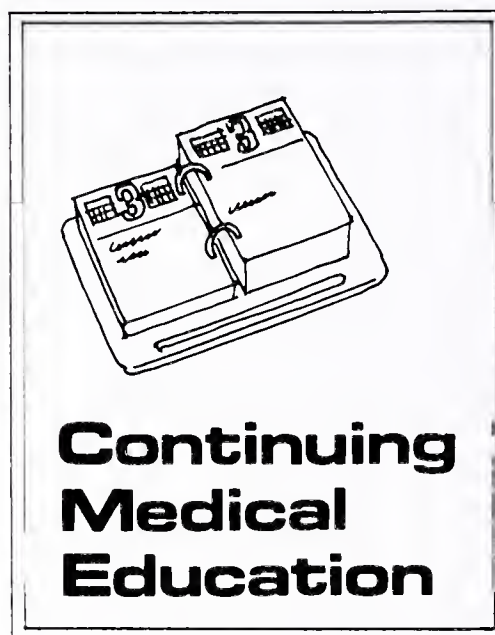
A study by the Hospital Association of New York State found that in the Empire State one-fourth of hospital costs, or more than \$1.1 billion a year, were attributable to meeting regulatory requirements.

At hearings on the Administration’s hospital cost-containment bill, Senator Ted Kennedy remarked: “A cost control program is needed. A program that is administratively simple, doesn’t create a new bureaucracy, and will result in significant savings.”

We could rightfully apply those words to the Voluntary Effort, spearheaded by the AMA, the AHA, and the Federation of American Hospitals in a coalition with insurers, consumers, manufacturers, business, labor, and local government.

In addition to giving the VE our conscientious best, we should tell our representatives in Congress, the media, and consumers about the difference between our voluntary success—and federal excess.

AMA EDITORIAL OPINION



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all “breaks”)

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. Dept of Medicine
  - A. Case Conferences First and Third Tuesdays, 12:30-2:00 p.m. Queens University Tower Room 618.
  - B. Grand Rounds Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.



2. Division of Nuclear Medicine
  - A. Technical aspects of Nuclear Medicine, Second Tuesday, 5:00-6:30 p.m., Queens University Tower, Room 413, 1½ credits.
  - B. Rounds, Fourth Tuesday, 5:00-6:30 p.m., Queens University Tower, Room 413.
3. Dept. of Obstetrics and Gynecology
  - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
  - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
  - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
  - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
6. Dept. of Psychiatry (resumes in September)
  - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
  - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room 11).
7. Dept. of Surgery
  - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
  - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
  - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
  - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., University of Hawaii, Manoa Campus, BioMed Building, Room T-210.

#### **Hawaii Thoracic Society**

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. 3rd Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

#### **Hickam Clinic**

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

#### **Hilo Hospital**

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.

7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

#### **Kaiser Hospital**

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
  2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
  3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea mnth. 8:00 a.m. 1 hr. Cat. I.
  4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
  5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

#### **Kapiolani-Children's Medical Center**

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

#### **Kuakini Medical Center**

1. G.I. Conference, 1st Tuesday, 8:00-9:00 a.m.
2. Nephrology Conf., 4th Wednesday, 8:00-9:00 a.m.
3. Oncology Conf., every Thurs. 7:30-8:30 a.m.
4. Surgical Conf., 1st, 2nd, Fri., 12:45-1:45 p.m.
5. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 12:45-1:45 p.m.
6. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, 1:00-2:00 p.m.
7. Ophthalmology Department Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
8. Surgical CPC, 5th Fri. 12:45-1:45 p.m.
9. Visiting Professor Lecture.

#### **Maui Memorial Hospital**

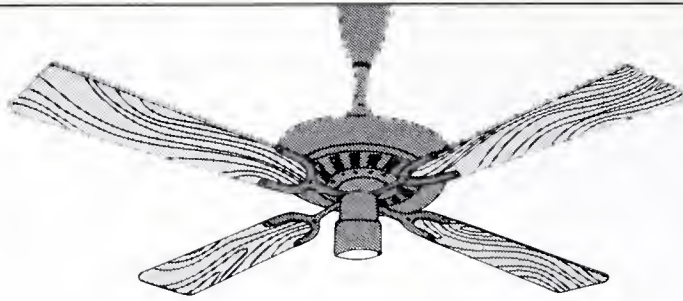
1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd.—Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., 3rd Mon., 7-8:00 a.m.
4. Family Practice Section—3rd Wed. 7-8:00 a.m.
5. Diagnostic Radiology—4th Tues., 12-1:00 p.m.

#### **The Queen's Medical Center**

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium  
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium  
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium  
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

#### **St. Francis Hospital**

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.



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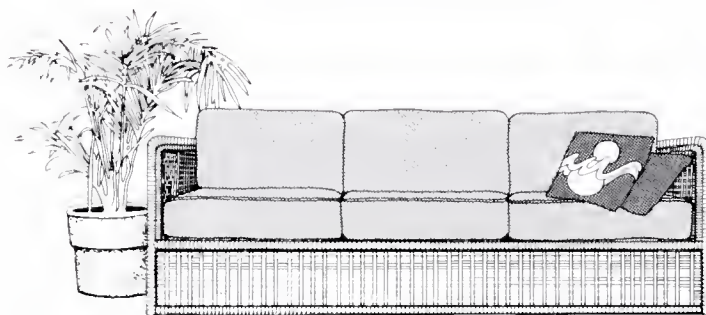
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5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Hematology Conf., 3rd Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
7. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

#### **Straub Clinic & Hospital**

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

#### **Wahiawa General Hospital**

1. Noon Seminars, Every Tuesday

#### **Wilcox Hospital (Lihue)**

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr.

Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: I, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

#### **SPECIAL EVENTS**

Aug. 4-11, 1979 Ophthalmology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.

Aug. 8-22, 1979 22nd Annual Postgrad Refresher Course, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Cosponsor: U of HI. Held: Honolulu, Maui & Kona. 39 hrs.

Aug. 25-31, 1979 Practical Manag. of the Infertile Clinic cospons. Tyler Med. Clinic and UOHJAB-SOM Dept. of Ob-GYN, Maui Surf. 16 hrs. CAT I.

Sept. 9-17, 1979 Practical Management of Anesthetic Problems, USC Sch of Med., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 31¼ hrs.

Oct. 8, 1979 HI Thoracic Society—Annual Mtg. 7:00 p.m. Fireside Chat, 7:30 p.m. 2 hrs. CME Cat. 1—Ilikai Htl. Honolulu. Contact: R. Respicio (808) 537-5966 for further info.

Oct. 8, 12, 1979 123rd Annual Convention-HMA/AMA Regional Mtg. Ilikai Htl. Honolulu. 5 days. Contact: HMA Office (808) 536-7702.

Nov. 19-21, 1979 "Nutrition, Sex and Controversy." 6:30-9:30 p.m. Mon & Tues; 1-4:30 Wed. 10 hrs. Cat. 1, no fee. Dept. of Ped., John A. Burns and Kapiolani-Children's. Contact: Wilma Schiner, Dir. of Training & Ed. 1319 Punahou St. Honolulu, 96826.

Dec. 1-6, 1979 American Medical Assn.—Interim House of Delegates Meeting Robert Hobart, HI Director, Dept. of Meeting Management 535 North Dearborn Street Chicago, IL 60610 Hdq. Hotel: S-W Agent: Not appointed

#### **MEDICAL MANAGEMENT PROGRAM**

- ♦ *Billing procedures that produce results*
  - ♦ *Insurance processing and follow-up procedures*
  - ♦ *Computer softwear analysis*
    - ♦ *Personnel efficiency analysis, training, policies, etc.*
    - ♦ *Inter-office communications*
    - ♦ *File systems and chart control*

**Verne Miller, MGMA, ARMA**  
Professional Management Services

**Amfac Center**  
523-2923

Dec. 6-9, 1979 American Medical Joggers Assn.  
Mr. Hugh S. Ames  
Honolulu Marathon Assn.  
P.O. Box 27244  
Chinatown Station  
Honolulu, HI 96827  
Hdq. Hotel: None selected  
Agent: Not appointed

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## OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.  
r0606



## Friday, June 1, 1979 320 Ward Avenue HMA CONFERENCE ROOM

### PRESENT:

Drs. Goto, Bell, Winn, Hindle, Hanlon, Chinn, Chang, Azman, Miles, Bruce, Cahill, Howard, Roth, Clingan, Fu, Char, Dang, Simmons, and Mrs. Nancy Simmons. HMA Staff present were: Messrs. Won, Saranchock, Leineweber, Ajifu, Ontai, and Mmes. Kendro, and Chang.

### CALL TO ORDER:

The meeting was called to order by President Goto at 6:00 p.m.

### MINUTES:

The minutes of the previous meeting were approved with corrections.

### REPORT OF THE SECRETARY:

The Council reviewed the Report of the Secretary as of May 31, 1979 which indicated that HMA membership totaled 904 in comparison to May 31, 1978 when membership totaled 871. Dr. Neal Winn pointed out, however, that as of June 15, it is anticipated that the membership total will be adjusted to 878, with 26 members being dropped for non-payment of dues and/or capital fund.

**REQUEST FOR REFUND:** The Council reviewed special requests for refund of dues for Dr. Donald Dietrich (now deceased) and Dr. Gilbert Sofio. In view of

the reasons presented, it was recommended that the dues be refunded on a prorated basis and that AMA be requested to take similar action.

### ACTION:

**It was moved, seconded, and passed that HMA dues for Dr. Donald Dietrich (now deceased) and Dr. Gilbert Sofio be refunded, prorated to the date of request for refund; and that HMA request AMA to take similar action.**

## REPORT OF THE TREASURER:

The April 1979 financial statement was reviewed in detail and approved subject to audit.

## REPORTS OF COMMITTEES AND COMMISSIONS:

**A. Cancer:** The Council reviewed a revised proposed HMA subcontract under the Community Cancer Program of Hawaii. The May 23, 1979 proposal projects HMA activity in the development and publication of Hawaii Outlines for Cancer Management (in areas other than the CPH target areas) for distribution to all practicing physicians in the State and placement in hospital wards and medical libraries. HMA would be required to contribute matching funds/in kind services. On behalf of the Cancer Committee, Dr. John Keenan recommended that the Council approve the proposed subcontract with the CPH. The motion was unanimously opposed.

The Council was also presented with an April 18, 1979 letter from the American Cancer Society to HMA. It was agreed that Dr. Goto would contact Dr. Francis Lock, ACS President, for clarification on the points raised in the letter. It was felt that HMA should reiterate to the ACS that we have worked well with the Cancer Society and have been satisfied with its efforts in the area of public education.

As HMA is frequently asked to respond to various requests in the area of cancer and inasmuch as it is difficult to respond without the background information, it was suggested that an appropriate committee be designated to prepare a statement which summarizes HMA's position on the Cancer Center and its relationship with other organizations who have supported the Center. The Council agreed that the Executive Director draft a position statement as suggested above with the assistance of a committee composed of the HMA President (as Chairman) and four other members who shall be the last four past presidents (Drs. Marion Hanlon, Calvin Sia, William Dang, and Winfred Lee).

The Cancer Committee also recommended that the Tumor Registry be moved to spaces reserved for it at the Cancer Center Building. The motion died for lack of a second.

**B. Computer:** Dr. William Hindle reported that the Ad Hoc Committee on Computers had met with representatives of consultant firm, Arthur Young and Company, to discuss its final report entitled, "A Review of the Data Processing Needs of the Hawaii Medical Association and its Affiliated Organizations," which was prepared as a joint venture of the HMA and BME. Of the five alternatives studied, the consultants have recommended Alternative No. 4 as the preferred approach—mini-computer shared by HMA and BME and interfaced with BME's continued use of a service bureau. The consultants have proposed to implement Phase 2 which would involve the development of a



request for proposal and solicitation of appropriate hardware and software from the available vendors. The Council was informed that costs thus far have amounted to \$5,300, and it is estimated that Phase 2 will amount to \$3,500 (costs to be prorated between HMA and BME). Since these expenditures fall within the budgets already approved by the Council and the BME Board of Directors, it was recommended that HMA proceed with Phase 2.

**ACTION:**

**It was moved, seconded, and passed that HMA proceed with Phase 2.**

*C. Request from UH College of Continuing Education:* Mr. Jon Won reported that the University of Hawaii College of Continuing Education has proposed that HMA join in co-sponsorship (with the College and the American Institute of Architects) of a one-day seminar on Income and Estate Planning for the Professional to be held on June 30, 1979. A recommendation was made that HMA's response be prepared such as to communicate that it would not be appropriate for HMA to enter in co-sponsorship of the proposed program as the Association is not a financial planning organization.

**ACTION:**

**It was moved, seconded, and passed that HMA not join in co-sponsorship of the proposed program.**

*D. Crippled Children:* Mrs. Becky Kendro reported that the Crippled Children Committee met on June 1, 1979 with the Chief of the Crippled Children Branch, Department of Health. It was learned that physicians who staff the crippled children clinics are reimbursed at the rate of \$28 per hour; however, it is becoming increasingly difficult to find physicians who can afford to give up their private practice in order to staff these clinics. In an effort to cope with inflationary pressures and overhead expenses (while the physician is away), the Crippled Children Committee recommended that HMA request the Department of Health to consider a reimbursement rate of \$60 per hour for physicians staffing these clinics.

**ACTION:**

**It was moved, seconded, and passed that HMA recommend to the Department of Health that it consider a reimbursement rate of \$60 per hour for physicians staffing the CCB clinics.**

The Council noted that the recommended rate is considerably less than the physician's usual charge, but

it is in keeping with reimbursement rates for other community services.

*E. Sports Medicine:* The Council reviewed a report on the HMA Sports Medicine Symposium held on Friday, May 4, 1979, at McKinley High School. The program was attended by 105 people and received favorable response overall. Plans are underway for future programs.

*F. Medicaid:* The Council also reviewed HMA's testimony of May 21, 1979, to the Department of Social Services on Medicaid Public Welfare Rules and Regulations. It was reported that Dr. Roy Kuboyama had met with the Director of the DSSH subsequent to the hearing.

*G. Legislation:* Dr. E. Lee Simmons reported that he and Dr. Goto had met with the Governor to communicate HMA's position on the Medicaid bill.

*H. 9% Solution:* Dr. Donald Char and Mrs. Becky Kendro reported on the proceedings of the 9% Solution conference held on May 25 and 26, 1979, at the Ala Moana Hotel. Dr. Char and Mrs. Kendro commented that the conference was informative and stimulating, and the sessions were devoted almost entirely to issues regarding manpower, primarily in nursing, medicine, and other allied health professions.

*I. Self Insurance:* Dr. William Dang reported that the Self Insurance Committee will be meeting on June 28 with representatives of The Doctors Company (from California). The Insurance Commissioner has been invited to attend.

*J. Medical Education:* Dr. Nadine Bruce recommended on behalf of the CME Committee that the HMA join in support of the National Council of State Committees of CME. The cost for joining this organization is \$200.

**ACTION:**

**It was moved, seconded, and passed to approve the expenditure of \$200 for HMA to join the National Council of State Committees of CME.**

Dr. Bruce also recommended that Ms. Delia Chang of the UH CME Director's office be appointed as a non-voting member of the HMA CME Committee.

**ACTION:**

**It was moved, seconded, and passed that Ms. Delia Chang be appointed as a non-voting member of the CME Committee.**

*K. Building:* Mr. Andrew Saranchock reported that the Building Committee met on June 1, 1979, just prior to the Council.

**HIGUCHI INSURANCE AGENCY, INC.**

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**HONOLULU COUNTY MEDICAL SOCIETY'S  
INSURANCE PROGRAM ADMINISTRATOR**

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**LEASING POLICY:** The Building Committee recommended that the Council adopt the following proposed changes in leasing policy for 320 Ward Avenue:

- (1) That the lease base be 95¢ per square foot *for office space only*, and that parking rents be negotiated and charged separately (current policy includes parking and office space as one package).
- (2) That the allocation of parking to tenants be done on the basis of 1 stall per 600 square feet (current policy is 1 stall per 450 square feet).
- (3) That staff be allowed to negotiate for shorter term leases, where feasible (less than 10 years and most probably 5 years).

**ACTION:**

**It was moved, seconded, and passed to adopt the above recommended changes in leasing policy.**

**TERMINATION OF LEASES:** Mr. Saranchock reported that two current tenants, Quenzer, Driscoll and Dawson and National Escrow Corporation, have expressed their intentions to move from their spaces at 320 Ward Avenue. Of the two alternatives available (assignment or termination of lease), the Committee recommended that HMA allow Quenzer, Driscoll and Dawson to terminate their lease, with the Building Committee approving the terms of termination. Inasmuch as a lease has been executed, members of the Council felt that the tenant should be held responsible for lease rents until such time that a suitable tenant is found.

In regard to National Escrow Corporation, it is expected that official notification of their intent to vacate their spaces will be received in the near future. The Hospital Association of Hawaii has indicated an interest in leasing approximately 1,000 square feet, and HMA is interested in the remaining spaces for consolidation of PSRO operations. The Committee recommended that National Escrow be allowed to terminate their lease, with the provision that they be held responsible for lease rents until a suitable tenant is found to occupy the spaces.

**ACTION:**

**It was moved, seconded, and passed that HMA allow Quenzer, Driscoll and Dawson and National Escrow Corporation to terminate their leases; that the Building Committee approve of the terms of termination; and that termination be subject to lease rents being paid until a suitable tenant is found to occupy the spaces.**

**It was moved, seconded, and passed that HMA offer (a portion of—approximately 1,000 square feet) the spaces (presently occupied by National Escrow Corporation) to the Hospital Association of Hawaii, within the guidelines just approved by the Council.**

**MAJOR MAINTENANCE:** The Committee recommended that HMA resurface its parking areas as soon as possible. The current estimated cost is approximately \$8,340, a considerable increase over the 1978 quote of \$6,000 which resulted from increases in the costs of materials used for resurfacing.

**ACTION:**

**It was moved, seconded, and passed to approve the resurfacing of the 320 Ward Avenue parking areas as soon as possible.**

**PARKING:** The Committee requested permission from the Council to pursue a contract with Diamond Parking, Inc. in an effort to gain more controlled supervision of the parking areas, with longer coverage, and at a comparable or lower cost than is presently being paid for a part-time attendant.

**ACTION:**

**It was moved, seconded, and passed that staff be allowed to pursue, up to the point of execution, a contract with Diamond Parking, Inc.**

## REPORTS OF COUNTY SOCIETY PRESIDENTS:

*A. Honolulu:* Honolulu County President Dr. Walter Chang reported that the HCMS Membership Recruitment Committee has been exploring various methods for recruiting new members. It was noted that while there are many individual reasons for physicians not joining the society, HMA, and AMA, one of the most commonly cited seems to be the "high" dues. At the Board of Governors meeting on May 29, several proposals were recommended to be undertaken as a pilot project in an effort to recruit new members. Approved by the Board were proposed concepts (1) rebate (or rebate in the form of credit) for regular members recruiting new members into the Society, and (2) membership dues payments in installments. While the criteria for such a membership drive must be developed in further detail, Dr. Chang suggested that the proposals be studied by the HMA Finance Committee. The Council was receptive to the ideas presented and *agreed that the proposals be referred to the Finance Committee.*

Mrs. Kendro reported that AMA Trustee, Dr. George Mills, will present the concept of a rebate or credit as part of a membership drive to the AMA Board of Trustees as a possible pilot project.

*B. Maui:* Maui County President Dr. Ben Azman reported that the Society's next meeting for members and spouses will be held on June 19 at the Maui Surf Resort, with Mr. Tom Boden (attorney) as the featured speaker who will discuss the topic of estate planning.

*C. Hawaii:* Hawaii County President Dr. A. Scott Miles reported that the Society's next meeting for members and spouses is planned for June 8, with Representative Herbert Segawa as the guest speaker. Dr. Miles noted that the June 8 meeting will be held in lieu of an AMA audio-visual program scheduled earlier.

## OTHER BUSINESS:

*A. Auxiliary:* Mrs. Nancy Simmons, Auxiliary President, reported that the Auxiliary recently held the first meeting of its new State Council, with HMA Public Relations Supervisor, Mrs. Ceci Young, as the guest speaker. Mrs. Simmons reported that they are trying to involve more of their members in Auxiliary activities.

*B. AMA Annual Meeting:* AMA Delegate, Dr. Herbert Chinn, recommended that the president or president-elect of each county society be invited to attend the July 22-26, 1979 AMA Annual Meeting of the House of Delegates in Chicago; and that HMA provide reimbursement under the guidelines of reimbursement.

**ACTION:**

**It was moved, seconded, and passed that the president or president-elect of each county**



medical society be invited to attend the July 22-26, 1979 AMA Annual Meeting in Chicago; and that HMA provide reimbursement under the guidelines of reimbursement.

#### ADJOURNMENT:

The meeting was adjourned at 9:40 p.m.



### Neurology of Musculoskeletal and Rheumatic Disorders

By Kenneth K. Nakano, M.D. Boston, Houghton, Mifflin Co. 401 pp. Price, \$40.00.

This book is clearly written in a simple, but non-condescending manner. The theme is to identify those points at which the nervous system abuts on the muscular and skeletal systems. Dysfunction or disease in any one of these three systems may cause profound and often interlocking changes, eg, cervical spondylosis.

One is prepared for each of the many clinical problems discussed in this text by reassessment of the neurological examination and neurodiagnostic procedures pertinent to this segment of neurology.

It can be recommended to orthopedists, rheumatologists, neurosurgeons, and neurologists, who will find much to savor. In the introduction, it is suggested that this book is suited to the needs of primary care physicians. I feel that most would find themselves much put upon by the detail and the neurological expertise demanded of them. Moreover, certain tables and figures are simply too detailed to be meaningful.

I would also take exception to the implication that sustained (false) clonus may be a normal concomitant of anxiety. Further, as is sometimes true of first editions, some x-ray reproductions are of poor quality and defy interpretation.

Finally, despite its frequency in clinical medicine, the commonly misdiagnosed syndrome of neurogenic intermittent claudication is not discussed.

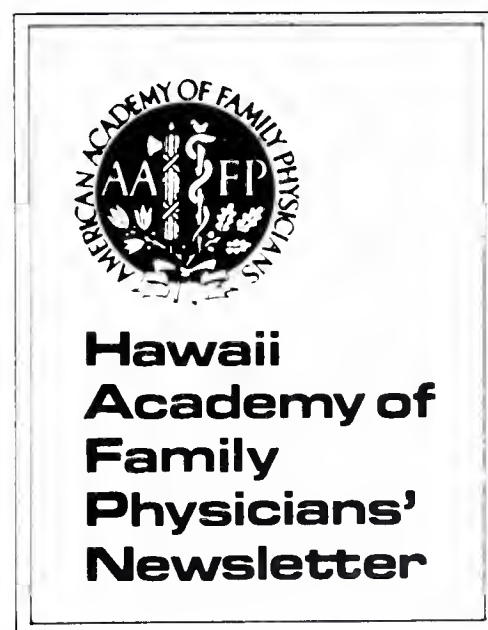
ROBERT HINMAN, MD



**Roy S. Adaniya, M.D.**

550 S. Beretania Street  
Honolulu, Hawaii 96813

Internal Medicine &  
Pulmonary Disease



J. I. FREDERICK REPPUN, M.D.

**New Members**—**Helena O'Connor MD** has joined the Waianae Coast Comprehensive Health Center as a Practicing Affiliate member of HAFP. Welcome to our ranks, Helena!

**Dropped from membership**—**Joseph Wasielewski MD** who is a Resident in pathology at St. Francis Hospital.

**Deceased**—our condolences to **Guy Heder** in Kahuku for the loss of his wife Dorothy Koolau Heder on 9 June; we knew her as the niece of Albert Kahinu, full-blooded giant Hawaiian with the most powerful and melodious singing voice on the island of Molokai.

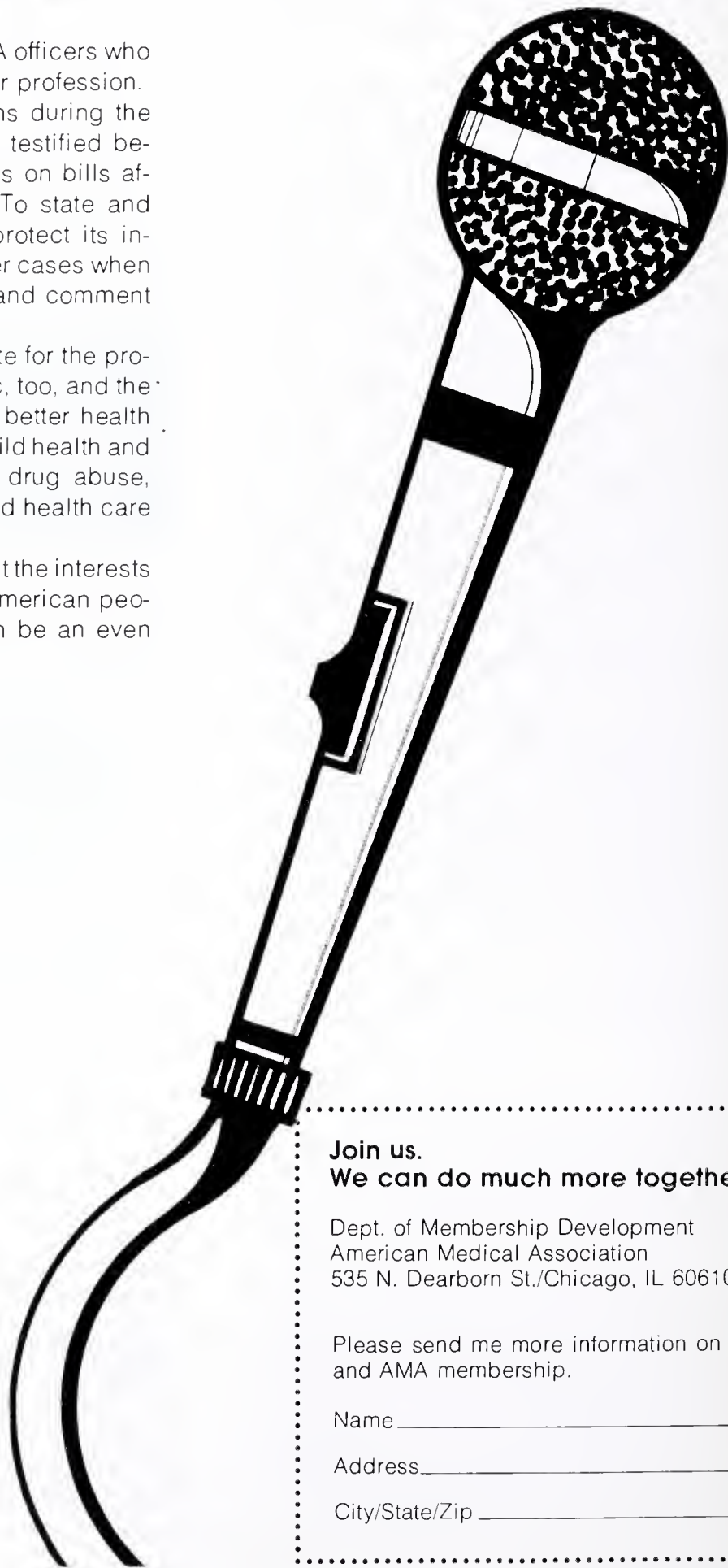
# "Mr. Chairman, Members of the Committee, I am Dr. Holden ... Dr. Palmer ... Dr. Beddingfield ... Dr...."

These were but a few of the many AMA officers who have gone to the Hill to represent our profession.

On more than two dozen occasions during the 94th Congress, AMA representatives testified before Congressional health committees on bills affecting the delivery of health care. To state and explain our profession's views. To protect its interests. In addition, there were 72 other cases when the AMA submitted written analysis and comment on legislation.

But the AMA isn't solely an advocate for the profession. It's an advocate for the public, too, and the passage of legislation for more and better health care. Legislation such as maternal, child health and crippled children services. Alcohol, drug abuse, and mental health programs. Improved health care for American Indians.

The AMA goes to the Hill to represent the interests of the American physician and the American people. With your support, the AMA can be an even more effective spokesman.



**Join us.  
We can do much more together.**

Dept. of Membership Development  
American Medical Association  
535 N. Dearborn St./Chicago, IL 60610

Please send me more information on the AMA  
and AMA membership.

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

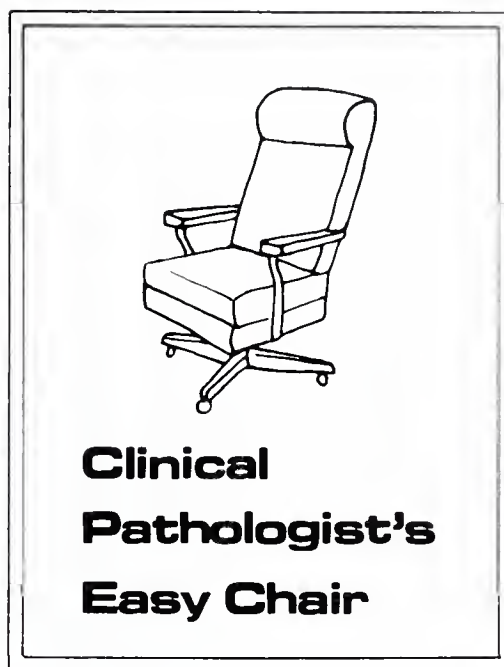


**News of Members**—**Fred M. K. Lam** hit the papers Sunday 6/3 as having been recertified for another 3 years as a member of AAFP; he was also mentioned, together with **Arch Wagle** of Naalehu in the previous issue of HMJ. However, joining them in being recertified were **Azman, Baysa, Bob Bell, Cahill, Druecker, Bob Harrison, Hattis, Heder, Homer Izumi, Doris Jasinski, Langworthy, Livingston, Machigashira, Reppun, Tesoro** and **Larry Wong**. **Cahill** and **Tsuji** did themselves proud on a TV program at noon 6/9 sponsored by HMA on the subject of "That Tired Feeling." **Al Burden** of Maui was mentioned in particular in the *Star-Bulletin* of 6/21 in "Key Mission of Nisei in the Pacific"; Al is not a Nisei, of course, but he is an Edoko, ie, born in Edo, the old name for Tokyo, and he served with the MIS (Military Intelligence Service) in World War II in the Pacific and Chinese theaters of war. **Glenn Stahl's** fierce mustachioed face graced the *Sun Press* issue of 7/4 which featured the new officers of the Kaneohe Business Group; he has also been appointed liaison between the Cancer Committee of the AAFP and our local chapter. **Homer Benson**, charter member and long-time general practitioner, announced his retirement from active practice on 14 June. **Mark Sowers**, ex Maui, then Hilo, then Ohio, has moved to Louisiana; a rolling stone can shake the sh... off its shoes, as the saying goes! **Bob Todd** has taken over from **Dave Swanson** (military assignment to the M'Td) as chief of the Dept. of Family Practice at Tripler and head of the Residency Training Program there; he sits on the Council of HAFP as Deputy to **Mike Hase**, chairman of the CME Committee of HAFP, and a welcome addition he is. He and **Pat Dietrich** have the up-coming joint meeting with the Canadians next February well in hand. With the departure of **Dave Swanson**, **Pat Dietrich** is now our President. **Bruce Hong** graduated from the UHSM '79 and is now at the U of Iowa Hospital as a Resident Affiliate member. **Dale Wicklund** is now an Active member, having completed his FP residency at TAMC and has transferred to Carlisle Barracks in Pennsylvania. Likewise **Bob Major**, Active and stationed at Tinker AFB. **Debra Hamburg MD**, UHSM '79 is a new Resident Affiliate member and in the FP Residency program at Kaiser, as are **Helen Petrovitch MD** and **Craig Kadaoka MD**. **Stephen Denzer MD**, UHSM '79, on the other hand is a new Practicing Affiliate member, so categorized because he is not in a FP residency but in the Flexible Program in the Honolulu hospitals. **Gwen Nishimura** is now an Active member working with Kaiser.

**Dinner Meeting**—at **Reppun's** on 30 June was well attended with a total of 63, including 6 student members and 6 guests. **John Newman** and his wife came all the way from Kauai. Steve Wallach brought us up to date on "Cardiology '79" and Acting Dean John Wellington MD, assisted by UHSM Public Relations man Gardiner Jones, gave an excellent slide show review of the goals of the UHSM and how these have been more than accomplished.

**CME**—Letters have gone out to all the large hospitals and to the UH School of Medicine asking that projected lectures, seminars and courses be cleared well in advance of their dates for categorization by AAFP as to "P" or "E," in order that our members may know what to attend for credit. Ralph Hale MD at Kapiolani-Children's has offered complete cooperation. A case in point was the recent "Adolescent Con-

ference" over 3 days that was excellent. Unfortunately, although it did receive category "P" from AAFP, this was not known until the day the conference began. Remember the Big One: The USC-UH-TAMC 22nd Annual Refresher PG Course August 11 to 22 at the Waikiki Sheraton and on Maui and Kauai.



FRANCIS FUKUNAGA, M.D.

## Serum Protein Electrophoresis

Serum protein electrophoresis plays an important role in the diagnosis of certain diseases such as multiple myeloma and nephrosis and is diagnostic for hypogammaglobulinemia and bisalbuminemia. In addition, many neoplastic, metabolic and infectious diseases may show nonspecific patterns. A normal report tends to rule out whole categories of serious diseases and abnormal results may point to more specific tests.

Electrophoresis is the differential migration of a mixture of particles placed in a direct current electrical field. The migration depends upon the electrical charge of the particle, its size, strength of the electrical field, and the nature of the support medium. The serum proteins become negatively charged in a basic solution and migrate to the anode. Routine electrophoresis of serum proteins separates them into five distinct zones, each of which is made up of several proteins. The fastest-migrating zone is albumin, followed by alpha-1, alpha-2, beta, and gamma globulins. The major components of alpha-1 globulin include alpha-1 antitrypsin and alpha-1 acid glycoprotein; alpha-2 globulin is made up of haptoglobin, alpha-2 macroglobulin, glycoprotein and ceruloplasmin; beta is made up of C-3 complement, transferrin, hemopexin and beta lipoprotein; and gamma globulin comprises five classes of immunoglobulins—IgG, IgA, IgM, IgD, and IgE.

Changes in the electrophoretic patterns are usually manifested by an increase or decrease in the concentration of normal components or by the appearance of abnormal proteins. The patterns in most diseases are not specific, and show an increase of one or more globulins and a decrease of albumin. Inborn genetic errors of protein production such as bisalbuminemia and hypogammaglobulinemia show diagnostic electrophoretic patterns.

The "stress pattern" is a nonspecific response to a variety of stimuli such as acute infections, malignancy, hypertension, metabolic disorders, myocardial infarction, and trauma. It consists of an increase of the alpha-2 globulin and a variable decrease of albumin. The alpha-2 globulin rise is due to a nonspecific elevation of haptoglobin and to a lesser extent of alpha-2 macroglobulin. Alpha-1 globulin may be normal or increased, and the beta fraction may be normal, decreased, or split. If the infection is prolonged or a local lesion such as an abscess develops, there will also be an increase of gamma globulins.

Malnutrition results in reduced protein synthesis. The total protein and especially albumin is reduced, while the globulins may appear normal or increased. The alpha globulins may increase to compensate for the decreased albumin to maintain colloid osmotic pressure.

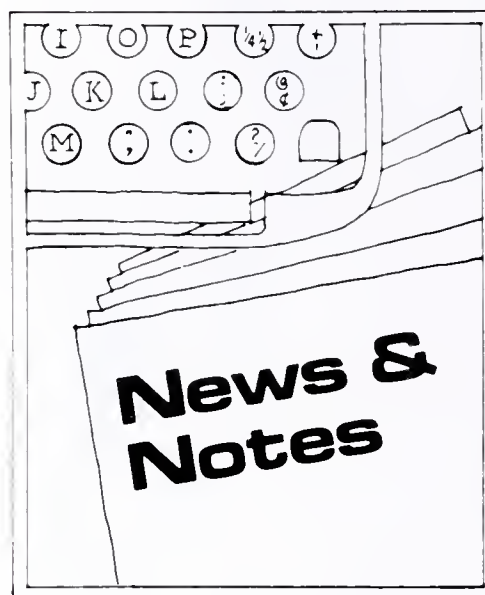
Nephrosis is characterized by a decrease of albumin, increased alpha-2 globulins—especially alpha-2 macroglobulin and low density lipoprotein—and a decrease of gamma globulins—especially IgG and IgA.

Chronic liver disease, especially cirrhosis, shows a decrease of albumin and alpha and beta globulins, and increased gamma globulins. The increase of IgA causes the beta-gamma bridging pattern. This pattern is more prominent on paper than on cellulose electrophoresis because of the better separation by the latter.

A broad increase of the gamma globulins, called polyclonal gammopathy, is seen in a variety of diseases such as various chronic infections, autoimmune dis-

eases, and other longstanding illnesses such as sarcoidosis.

Monoclonal gammopathy is characterized by a homogeneous protein band that may be located anywhere between alpha-2 globulin and gamma globulin. This pattern is characteristic of multiple myeloma, macroglobulinemia, and light and heavy chain diseases. The monoclonal peak may not be obvious in light chain disease, and the only clue may be hypogammaglobulinemia. The urine in these cases should be electrophoresed to detect Bence-Jones proteinuria. A monoclonal pattern may sometimes be seen in non-malignant conditions, and the incidence increases with age. The peak in these cases tends to be low and the other immunoglobulins are not usually depressed. These patients should be followed periodically because some of them may eventually present with a malignant type of monoclonal gammopathy. The interpretation of a monoclonal pattern must be made with care because contaminating hemoglobin and fibrinogen will give an apparent monoclonal peak.



HENRY N. YOKOYAMA, M.D.

## Life In These Parts

"Dr. Sharon Bintliff of Children's Hospital was a surprise hit at the Western-themed party tossed by John Finney and Tiare Richert to promote the Honolulu Club. Dr. Bintliff, appropriately attired in cowboy boots, jeans, Western shirt and hat, did a little stomp dance that had the mark of authenticity about it." (Dave Donnelly's Hawaii ... Ed: *And why shouldn't it? She's an original Texan ...*)

"Dr. Wayne McKinney's 'Far-Out Fortune Cookies' are the prizes given at the American Cancer Society exhibit at Ala Moana Center. But they didn't contain yer average fortune—wood-jabeleve: 'He who smokes gets yick lung.'" (From george daacon)

Interesting title for a medical column: "Hanabata nose" by Richard Adler who writes "Medical Matters:" for the *Hawaii Tribune Herald* ...

Senate Bill 1611 became law when Governor Ariyoshi signed it into Act 143 ... Beginning July 1, all women applying for marriage licenses will be tested for rubella susceptibility as well as for syphilis ... Even if she turns out to be susceptible, it will not preclude her from getting married ... Ned Wiebenga, state epidemiologist reports that the DOH is setting up a clinic where counselling and immunization against rubella can be given and the Legislature has appropriated \$50,000 for this year ...

George Saviello, director of operative services for Kapiolani Hospital announced that the hospital has opened a



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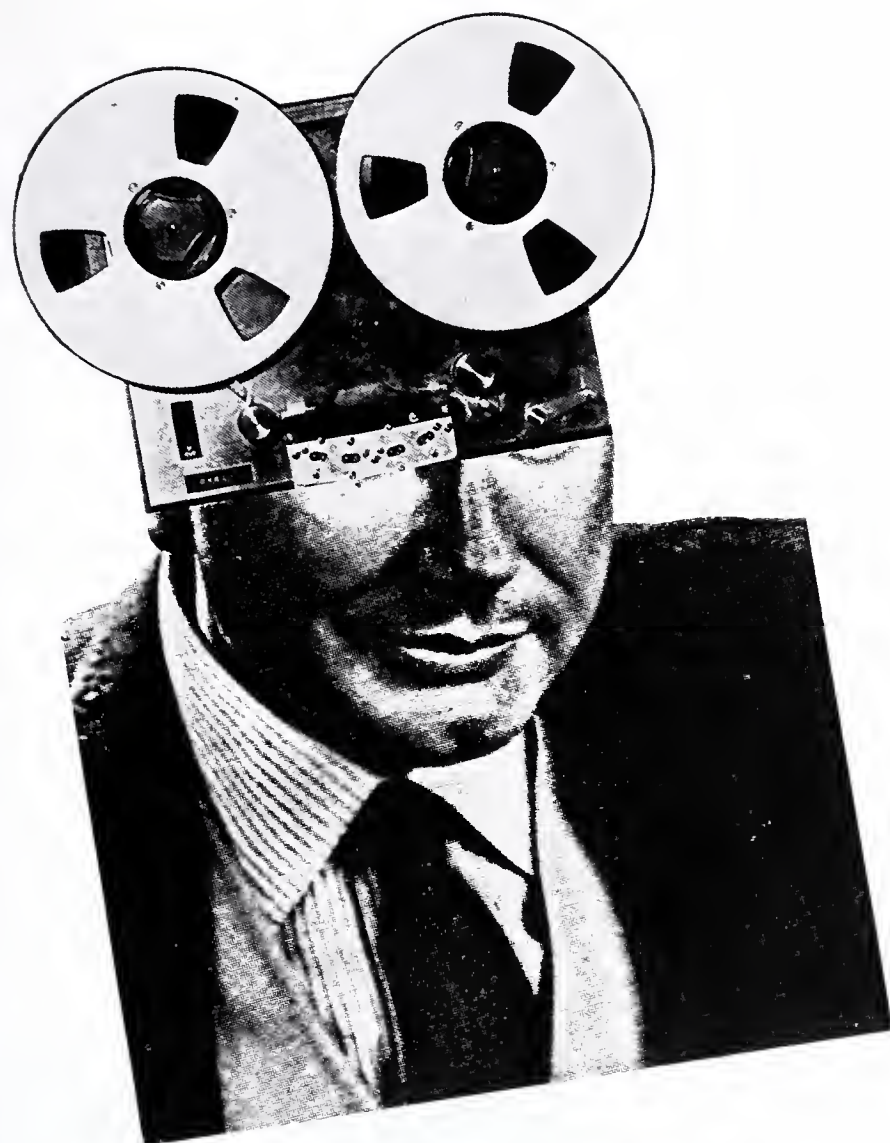
Sincerely,

*Paul S. Isenburg*

Paul S. Isenburg, Ph.D.  
Director  
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686





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new perinatal center that offers special intensive care to women with high risk pregnancies . . .

J. Ward Russell, former state senator and executive of Hawaiian Telephone Co., had a heart attack and survived. He writes: "**Mort Berk**, my cardiologist and long time friend, summed it up perfectly the other day when he said, 'Russell, I've known a lot of s.o.b.'s in my lifetime, but you're without doubt the luckiest s.o.b. I've ever known.' " Ward was apparently jogging across the street from the Outrigger Canoe Club when he "conked out." Another jogger, **Henno Tarikas**, a radiology assistant at Straub, was 50 to 100 yards behind him and started CPR. **Sharon Bintliff** who was having coffee in the Outrigger Canoe Club also dashed to his rescue. Sharon did the chest pumping and Henno administered mouth-to-mouth resuscitation. The ambulance crew arrived with CPR equipment . . . "Incredibly lucky—Sharon wouldn't give up! I understand when she arrived on the scene, my heart was fibrillating . . . Minutes passed, still no pulse, but she wouldn't stop pumping . . . Finally, evidently as a last resort, I was 'zapped' with an electrical shock. No response. The ambulance attendants shook their heads . . . Sharon refused to stop and kept on pumping . . . Suddenly a blip appeared on the screen, then another and another, and my heart was working . . . Luck continues to smile on me . . . I'm back at the office feeling fine—except for a helluva sore chest . . . But I'm not complaining!"

Proud father, **Bob Wong** writes: "Enclosed is a copy of my son (and **Dr. Bradley Wong's** brother) Stephen's appointment to the faculty of Temple University School of Medicine. In addition to this appointment, he will be serving as the retinal surgery consultant at Philadelphia Naval Regional Medical Center . . . He began his medical studies at the UH School of Medicine . . ." (Ed: *Bob should be equally proud of Brad, surgical resident here.*)

"Smoke Signals: **Drs. John Wagner** and **Jack Scaff** say 'They're genuinely discouraged over the poor results of various stop smoking clinics' and surprised that 'everything is geared to the chronically addicted adult smoker—there are no single serious programs aimed at teen-age smokers.' So they're huddling with Jerry Conover of Hawaii Heart Assoc. about organizing a stop-smoking clinic for teenagers, taking the clinics right into the high school . . ." (George daacon Jun 29)

Ned Wiebenga, chief of DOH epidemiology branch has recommended that mumps vaccination be added as a school-entry requirement effective July 1. Ned reports, "Only 59% of the students entering school here for the first time are immunized against mumps, bringing the rate to an all time low . . ." The DOE notes that some unfavorable reaction to the proposal "may be expected from groups on grounds that such immunization conflicts with their bonafide religious tenets and practices." (Ed: *Absolutely asinine!!!*)

Three "born-again" Christian doctors who use faith in God in their everyday practice of medicine say, "Jesus is the supreme healer—and if we, as physicians, can avail ourselves to him as tools of healing, then we can be the best of doctors." **Werner Schroffner** was born in Austria as a Catholic, **Gary Fujimoto** as a Buddhist and **Joseph Brock** as a Protestant . . . All three had experienced similar disenchantment with organized religion during their medical school years, but each had a revelatory experience in which he made the conscious choice to ask Jesus Christ to come into his life . . . Werner says, "I think recognizing God is a part of maturing—recognizing that man's knowledge is pitifully small in comparison to His." Joseph Brock says, "When you're born again, you feel the assurance that God will help you with problems that occur if you release the burden to God." Gary Fujimoto says, "My view is that science has only discovered the laws of God. They were there all the time and man did not invent them . . ."

"As if three daughters and a wife, Ann, weren't enuf women around the house, **Dr. Jordan Popper** was gifted with belly dancer Shalimar Sunday" (George daacon May 22)

**George Mills** reacted to President Carter's national health plan: "It is impossible for me to see how the president can propose increased health care benefits and restrict medical

costs without rationing care or decreasing the quality of the care at the same time."

#### Report on Tel-Med: Top 20 tapes for 1978

1978 Rank	Tape #	Title	No. of Calls	1977 Rank
1	1,050	Male Sexual Response	2,865	1
2	898	Female Sexual Response	2,845	2
3	12	Am I Really Pregnant?	2,712	5
4	137	Marijuana	2,348	3
5	8	Venereal Disease	1,720	7
6	1,180	Homosexuality	1,633	4
7	57	The Rhythm Method	1,237	8
8	172	Acne, Heartbreak of Adolescence	1,182	9
9	15	Syphilis—Early Treatment— Early Cure	1,174	—
10	16	Gonorrhea	1,133	—
11	1	Vasectomy	1,058	—
12	24	Abortion	948	10
13	67	Warning Signs of Pregnancy	944	6
14	404	Brothers & Sisters Getting Along Together	899	—
15	147	The Lady Living Alone	849	—
16	11	Are You a Hidden Diabetic	843	—
17	6	Breast Cancer	804	—
18	31	Vaginitis	787	—
19	42	I'm Just Tired, Doctor	764	—
20	408	Discipline & Punishment— Where Do You Stand	760	—

## Physicians Speak Up, Part I

**Mort Berk**, cardiologist-master chef has the following to say about salt-free restaurants: "Many of the better restaurants will prepare food without salt if they are asked to do so . . . This is particularly true where they have broilers and a piece of chicken, meat or fish can be broiled dry without any



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salty butter or any salt added to the entree . . . Where it is not possible (ie, to serve salad without salted dressing) substitution of lemon wedges provides an excellent substitute . . . Boiled rice is completely free of salt and is available in most restaurants in Honolulu . . . It is important to ask the waiter or to tell the waiter just exactly what you want and what you don't want. If they cannot follow your instructions, then you know you've hit the wrong restaurant and cross it off your list. It is a good idea before going to a restaurant to call and ask whether they can provide the kind of meal that you need . . ."

Our Editor-in-Chief and dermatologist **Harry Arnold Jr.** (alias HLA2) had these comments to make re, a Feb. 14 *Star-Bulletin* article, "New Acne Drug May Be the Cure": "It was an unfortunate, overly forceful statement, likely to rouse false hope of early cure for hundreds or thousands of afflicted teenagers . . . The drug, a modified form of vitamin A, has been shown to be astonishingly effective in severe, deep, treatment resistant, cystic acne . . . Of 33 patients treated at the National Institutes of Health 19 experienced 75 percent improvement and 13 of these cleared completely. The acne relapsed and had to be treated in 10. In 14, it became worse! Those who did clear remained clear for a long time after treatment stopped, as long as two years in a few cases.

"Finally, it is unlikely that the drug will be approved for sale in the U.S. before the end of 1980, if then.

"The moral? Medical advances ought not to be so forcefully publicized until the release has been discussed with physicians who can clarify them a little."

Another HLA2 gem comes from the *Honolulu Advertiser* Mar. 2 issue which we nearly missed . . . We extract therefrom: "David Lawrence Eyre's Commentary to the effect that the poor need daily help, not just help at Christmas, reminded me of Ralph Waldo Emerson's wife's assertion that 'it is wicked to go to church on Sunday.'"

Of course Eyre is quite right, and we all know it and that is what the DSS and the Aloha United Way are all about. But his implication that what the poor really need is just redistribution of wealth reminded me of a scientific parable published 20 or 25 years ago in the weekly magazine *Science*.

The author in this article said that a few decades ago, it became possible to describe accurately the distribution of velocities among the fast moving molecules in an enclosed volume of gas. It was found that the velocities were very unequally distributed. A very few molecules were moving extremely fast; a larger number were moving at moderate speeds; and the largest number were moving very slowly.

This inequality of velocities aroused only passing interest, and no indignation or even any objection to it was made by anyone. But then it was noted that wealth was distributed in exactly the same way . . . This aroused a great deal of interest and concern, and a lot of indignation, and there were outcries against its unfairness, and pleas for equalization of distribution of the money, so that we would all have somewhere near an equal share.

Now since this remarkably unequal or 'skewed' distribution is characteristic of so many different things—it seems probable that it is an expression of a basic natural law . . .

If so, then in our desire to equalize the distribution of wealth, we ought to take a long, careful look at what happened when we tried to equalize the speeds of the molecules in a gas. They had to be slowed to a standstill for it to work. Equalizing the distribution of wealth might very easily work out the same way . . .

It seems pretty likely that we are already going almost as far as biologic law will let us in redistributing wealth through the mechanisms of the graduated income tax, unemployment insurance, welfare and public and private charitable efforts. The points of diminishing returns cannot be very far off; in some areas, notably unemployment insurance, it may have been reached some time ago.

Biologic law is not easy to get around. As Horace said a long time ago, 'You can throw Nature out with a pitchfork, but she will keep coming back.'

We found the following intriguing article by a R. G. Ursul in the *Windward Sun Press* entitled, "Frissell: Against

Socialism" (Ed: As an ardent admirer of this outspoken man of principles, we have extracted liberally.)

"Dr. T. F. leans back in the chair, takes off his glasses and considers the question. As an eye physician and surgeon—how does he perceive the current fight between the ophthalmologists and optometrists? 'I don't give a damn,' he says, the corners of his lips breaking into a quick and knowing smile. 'All they've asked me for is my testimony and a donation.' . . . The likeable, outspoken and frank **Frissell** does get upset, however, when the subject becomes national health medicine. 'I'm opposed to socialism of any kind . . . We're going that way. Medicine attracts the arrogant and politically they blow it. Health medicine is called a rationed product of Britain. In Canada, the physicians are paid by the patient and are limited to the number of patients they can see. I practice good medicine because I like a good income. I work long hours. I work my ass off.'

'None of the surgery I do is necessary,' he adds. 'They'll all live without it. The government can get me any day of the year for unnecessary surgery.'

'As a man? I'm a loner. In politics? I would be described as a libertarian-anarchist.'

The interview had to end with his assessment of himself . . . 'I'm a short-tempered, old bastard,' he said, rising to shake hands. 'I don't know if I told you anything,' he added . . . 'But I hope it helped.' It did—with an almost breathtaking and welcome clarity."

## Miscellany

The pleasant haole nurse at Kuakini ER who must be taking beginning Japanese conversation feels that orthoped **Akira Kutsunai** is akin to the barefoot practitioners of China. "Kutsunai" can mean "without shoes" . . .

## Sportsmen

Pathologist-golfer **Frank Fukunaga** walked thoughtfully up to his drive on the 18th Hole at Mid Pac on Thurs. afternoon, July 12 . . . He mulled over the lie, the windage, the pin position, the distance, the ever threatening OB on the right, and the fact that his team was losing. He made a resolute decision and grabbed his trusty 5 wood. He went through a **Nobu Nakasone** count down and swung his club in a perfect full arc . . . The ball rose majestically, hooked ever so slightly, landed on the right side of the green and headed straight for the pin . . . Kerplunk! It dropped in for an eagle . . . and a creditable net 68 . . . Frank smiled happily, one of his rare happy smiles on the golf course . . .

Hing Hau Chun of the "Hunky Bunch" received a Ms Fixit Aloha Club for administering first aid to the brother-in-law of a G. K. Lowrey who collapsed from heat exhaustion during a 15 kilometer Norman Tamanaha run . . .

"SEE HOW THEY RUN: 'The Woodstock of running' is how Dr. Jack Scaff described the Primo Relays (May 27) which attracted nearly 7,000 participants, slightly more than the number that entered the Honolulu Marathon . . . Scaff, incidentally, wants to apologize for waking up half of Hawaii Kai at 5:30 am when he came on the loudspeaker to announce the start of the race . . ." (George daacon)

Tommy Kono, one of the greatest weightlifters of all time, has nominated **Dr. Richard You**, his trainer, advisor and friend for the Hawaii Sports Hall of Fame. As Bill Gee, sports editor, comments, "The wonder is that the Hall of Fame Selections committee somehow did not induct him in 1978." Herein are excerpts from Tommy's letter: "I nominate Dr. Richard You for the Hawaii Sports Hall of Fame in weightlifting because of his dedication and support as physician, coach, trainer, manager and promoter of the sport in the 28 years I have known him . . . His unwavering belief in the values of weight training made him a crusader for weightlifting during an era of public disinterest in the 1940's and early 1950's. He was the only person in Hawaii who promoted weightlifting, physique and health shows from 1950 through 1970 . . . Dr. You's annual trips to the National championships and AAU conventions, also to Olympic and World competitions as a representative of Hawaii is well



known and documented . . . He has, without any thought of monetary returns, assisted all potential champions in their nutritional needs . . .

## Professional Moves

The pace is picking up, but we are still rummaging through June and early July clippings . . . In Honolulu, cardiologist **James Orbison**, who has been QMC medical director all these years, joined fellow cardiologist **Samuel Gresham** at 747 Amana Street, Suite 219 and in Wahiawa, the Medical Arts Clinic, Inc. relocated to 302 California Ave. The Clinic includes FP's **Norberto Baysa**, **Richard Tesoro**, **Daniel Whang** and **Roy Koga**, internists **Angelita Catalan** and **Jim Blattau** and general surgeon **Manuel Abundo**.

Most of the action is in the outer islands esp. on the Big Island. OB man **John Uohara** opened his office at 670 Ponahawai St., Suite 200, Hilo, Hawaii, pediatrician **Patricia Nevius** and FP **Edward Briscoe** joined the Hilo Medical Group, Inc. at 1292 Waianuenue Ave., Hilo. On Maui, OB man **Glenn Aggerup** opened at 1939 Vineyard St., Wailuku and plastic surgeon **John McCurdy** opened at Puuone Plaza, 1063 E. Main St., Wailuku. (As Dave Donnelly, columnist, puts it: "Maui is getting very uptown—the Valley Isle now has its first plastic surgeon.")

Speaking of firsts, FP **Jane Fryberg** expects to be the first full time physician in Hawaii Kai when she opens her office on Aug. 1 in the Grant Building. Jane is a 1975 grad of the UH Medical School, a mother of four, who has worked at the Job Corps Center in Hawaii Kai, at the UH Student Health Center and presently works at Kaiser Hospital emergency room. She formerly taught high school in the DOE before turning to medicine . . . and is married to a physician to boot . . .

## Oncology Conference

A 72-year-old woman has recurrence of thyroid papillary carcinoma, 7 years after a total thyroidectomy and post op radiation therapy . . . Nuclear med man **Dick Warsnick** reviewed the scans and commented mysteriously, "We can resort to cruder forms of therapy . . . this time . . ." Pathologist **Grant Stemmerman** also added enigmatically, "This calls for nonradical radical neck treatment of thyroid CA." Endocrinologist **John Kim** was specific: "TSH output has to be suppressed with thyroid eg, Synthroid 2 to 3 mg or as much as she can tolerate." Oncologist **Kevin Loh** was pessimistic: "Prognosis is poorer in women over 50 and in men over 40 . . . The more metastatic nodes, the better the prognosis . . . Thyroid CA is resistant to radiation and to chemotherapy . . ." **Dick Warsnick** agreed, "The cornerstone of therapy is TSH suppression." And Stemmy added for general information: "Recent epidemiologic studies of occult thyroid CA show that increased thyroglobulin can be related to CA and recurrence . . . Normal thyroglobulin is 20 and rises to 500 in patients with recurrence."

A 72-year-old woman had surgery for adenocarcinoma of the endometrium with focal left tubal lymphatic invasion . . . **Larry McCarthy** was ecstatic and proudly showed a lovely slide of the gross specimen . . . Fellow pathologist Grant Stemmerman commented, "That's truly a magnificent picture . . . It's the first such picture in 20 years . . . Most are screwed up by radiation by the time we get it . . ." Moderator **Quint Uy** asked quizzically, "Are you suggesting we not radiate preop?" Stemmy was emphatic, "No! No! We now have our one slide . . ." Turning to **Kevin Loh**, Stemmy asked, "Can you comment on the use of progestational drugs?" Kevin: There is a 30% objective response esp. in the elderly and in well differentiated tumors. But chemotherapy should not be ruled out for endometrial CA . . . It's the same as for the ovarian CA protocol . . . Recurrence is 70-80%. We can use alkylating agents." **Noboru Oishi** added, "The cure rate for endometrial CA is an overall 65% . . ." Kevin quoted further statistics: "With a single agent, we get a 20% response rate . . . With combination therapy, a 60% response rate."

Radiotherapist Ed Quinlan added: "With radio therapy, the key words are low grade and small uterus . . ." Moderator Quint Uy asked Ed, "When was the last time you counted your radium needles (referring to the recent incident at Queens Med Center)." Stemmy asked, "What tests can determine spread via the lymphatics . . ." Larry McCarthy pointed out, "Metastatic spread is related to competent platelet function . . . In the March issue of *Cancer*, Arlie Clark of MD Anderson observes that post surgical and post radiation head and neck tumors had fewer metastases with platelet aggregation inhibition . . ."

Surgeon **Bob Oishi** reported "In colon CA, I've been interested for many years in preventing metastasis with heparin . . ." Quint Uy added, "The idea of heparin was suggested a long time ago . . ." Getting back to Stemmy's original question, Kevin replied, "The two tests would be lymphangiogram and CAT scanning . . . But I would reserve them till after radiation therapy . . ."

## Oncology Dialogue

A 65-year-old oriental woman who had her workup in Hilo including UGI series, gastroscopy and biopsies was sent here for gastrectomy. Pathologist **Larry McCarthy**, simply enthralled by the slide photograph remarked, "What a beautiful gross specimen." Fellow pathologist **Grant Stemmerman** added: "It shows hypertrophic changes and 4 times normal staining for intestinalization, with superficial spread of carcinoma . . . Surgeon **Bob Oishi** lamented, "You can't feel the superficial spread . . . We must depend on the endoscopist for proper demarcation of the biopsy sites . . ." Grant showed on the blackboard a **Gary Globber** scheme for zone demarcation of the stomach . . . A third Kuakini pathologist **Takushi Hayashi** commented while reviewing his electronmicroscopic slides: "I agree with Dr. Oishi that you can't delineate the spreading area by palpation when it is spread through the lamina propria . . . There was a single positive node in the prepyloric area . . ." Stemmy predicted, "I have the gut feeling that this patient has a good prognosis." Surgeon **Francis Oda** inquired, "Is it micro or macrometastasis?" Stemmy: "Micro metastasis definitely . . ."

Moderator **Quint Uy** turned to oncologist **Kevin Loh**: "Kevin can you summarize immunotherapy in Stage II micrometastasis?" Kevin was less enthusiastic: "No study is available which shows any significant results with either immunologic or chemotherapeutic modalities . . . I think survival is less than 50% . . ." Stemmy dies hard: "Well then, it will be 49%." Quint reminded the group, "Not too long ago, everyone was talking about immunotherapy as a cure for breast and stomach CA . . . What's happened to that enthusiasm?"

## Physicians Speak Up, Part II

**Phyllis Wright**, pediatrician and chief of Crippled Children Branch of DOH feels there are at least two other factors besides the amount of alcohol imbibed which may affect fetal development . . . The stage of development of the fetus at the time the mother drinks; drinking at various stages causes different kinds of abnormalities. "Binge drinking" during the first trimester is probably the most serious hazard to fetal development . . .

David Sachs, 47, is a man of many seasons . . . "Stay good," he says, not as a routine platitude, but rather as part of his philosophy. "We're all generally delivered here both well and good and it's our own responsibility to stay good . . ." David has been a heart surgeon with a lucrative practice in Beverly Hills, assistant professor of surgery at UCLA, a movie actor, a TV host and the author-illustrator of four work books for children. David says, "People have to learn that you can only have self respect and pride when you are in control, when you know the parts of your body and how they work. Once you have that, no one can control you. You're free. That's what health is all about."

Commenting on Ira Glasser's article "You Can Be Fired For Your Politics," **Bruce Joseph** writes: "However, I am



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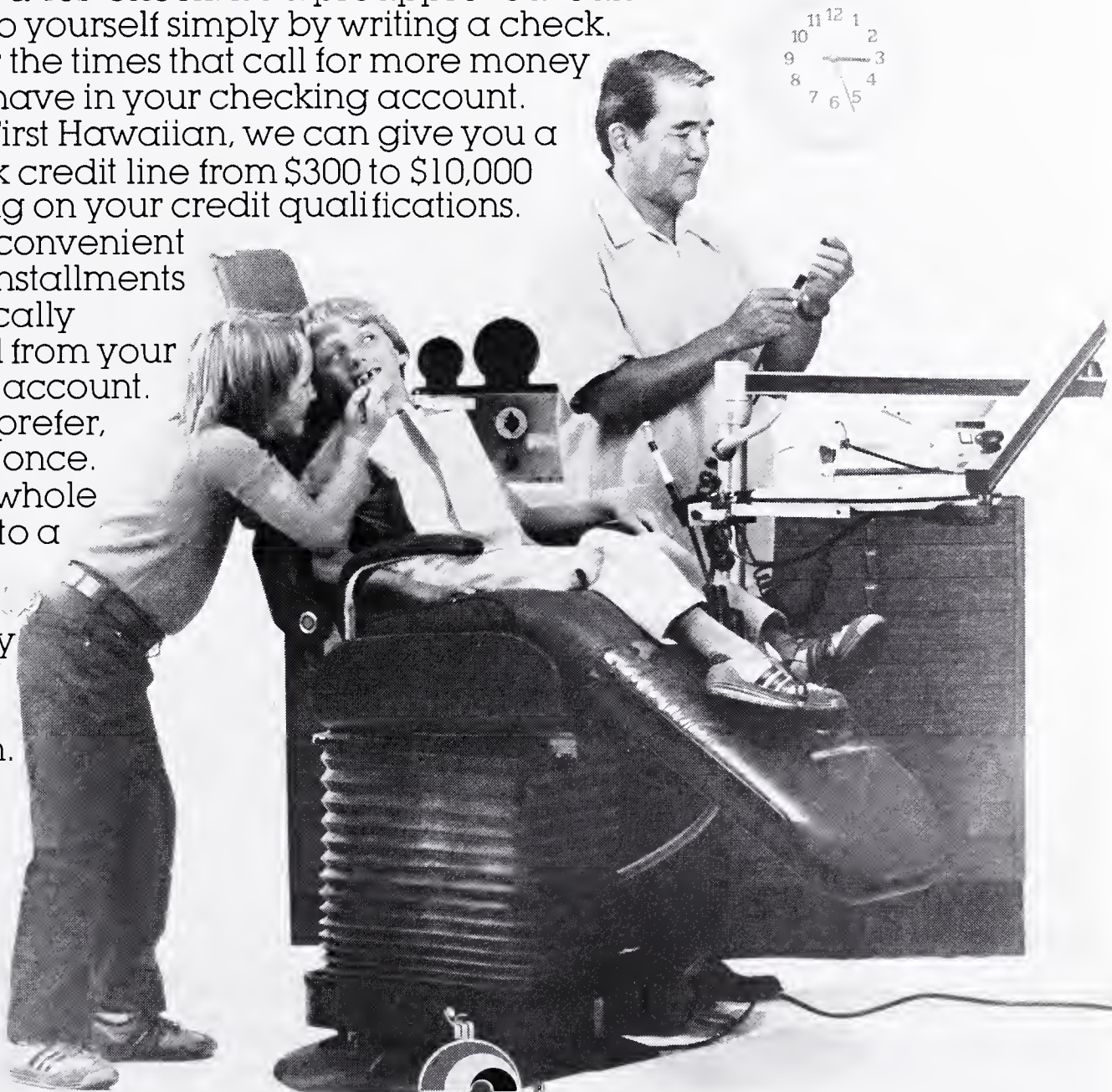
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afraid that the ACLU will continue to press for more legislation, not only to prevent employers from discriminating on the basis of race, sex, religion, homosexuality or heterosexuality, political beliefs, et cetera; but also to prevent discrimination against those that are too short, too tall; too fat, too thin; with hair too long, et cetera . . . However, as such anti-discriminatory legislation is passed, it involves the hiring of additional bureaucrats and attorneys to implement, investigate and enforce the various statutes . . . I hope the ACLU and our legislators have the good sense to know when to stop, before all productive enterprise in the United States grinds to a halt under the weight of excessive regulation." (Ed: *Well put . . .*)

**Jack Scaff** on Death Penalty & Crime: "A truly objective editorial should have mentioned that polls conducted by *The Advertiser* indicate that the support of the death penalty is a public majority opinion increasing on a daily basis . . . My specific complaint, is to the statement "Objective studies have shown, moreover, that having the death sentence as part of the law doesn't tend to deter crime . . . I am, therefore, calling upon *The Advertiser* to support its claim by fact, rather than innuendo . . . *The Advertiser* wants only a taint of justice, hoping that we can simply slap criminals on the hand; the death penalty, evidently representing more justice than can be coped with.

To hope that improved police investigation will help is begging the issue. The police in Honolulu, for example, do an excellent job; that is, the criminals are caught, their guilt is rarely questioned, the case being then thrown out on procedural and technical errors, some as minor as misspelling of words. Once again, indicating we don't want real justice, but just to play at the game. That criminals go free for years while their cases are appealed to death, would be laughable, except for the sickening results . . ." (*The Advertiser* editorial responding to Jack merely listed State Health Department records during the 10-year period preceding rescission of the death penalty in 1957, the murder rate was 4.3 per 100,000 and during the 10-year period immediately after abolition of the death penalty, the murder rate dropped to 2.9 per 100,000. In summary, the editorial infers that the preponderance of evidence, is that the death sentence as part of the law doesn't tend to deter crime.)

Our favorite social critic **Fred Reppun** has a novel suggestion re, land tenure: "The land—and the ocean—of Hawaii Nei is becoming so scarce to come by, so precious, so overburdened with false and inflated values that have been generated by speculation and gambling, that the owner does not realize he himself has perhaps contributed absolutely nothing to the soil—in fact, he has often abused the land and the ocean—that he really should have no right at all to something that has been repeatedly raped by the dollar . . .

Maybe we need to think about going back to common ownership—to the concept that the land and water and air and sea of Hawaii belong to all of us who claim beloved Hawaii as our home.

Think of it! Consider seriously that all this that is so beautiful might be put into a bank and be guarded as a precious thing, preserved in righteousness—Ua mau ke ea o ka aina i ka pono—and that those of us who live on and in it, and use it, have the right to do so only, only if we continue to do so with loving caring for it, not abusing it, conserving it and not speculating or gambling it away, using it in conformity with and respect for our neighbors, allowing the laws of our society to prevail and planning laws for the good of all.

All of us might be attending the birth of a quiet revolution, perhaps a much needed revolution in concepts of land tenure and tenancy wherein the landlord may turn out to be ourselves!"

Hors De Combat

Sperm or no sperm, that is the question . . . Vernon Reiger Sr. was on trial for rape and attempted murder. Pathologist **John Hardman** of Kapiolani Children's Hospital testified that the seminal fluid found in the victim after the

Feb. 26 attack contained no sperm, making it likely the attacker was a man who had undergone a vasectomy. The prosecution used that finding, with information that Reiger had indeed had a vasectomy to back its charge that Reiger was the attacker who raped and shot the victim . . . Urologist **Herb Chinn**, however, testified in court that he had conducted the delicate operation on Reiger in 1976 to reverse the earlier vasectomy so if "a semen sample taken from the victim after the attack had no sperm it was probably not Reiger's because I would expect to find some sperm." Herb testified that a test a month after the reversal operation showed Reiger did issue sperm, though the count was lower than expected . . .

Another pathologist, **Al Majoska** was also under fire . . . A police officer had filed a \$1.5 million lawsuit against Al claiming that the city Medical Examiner had maliciously classified the policeman's wife's death as a homicide, despite evidence that her death was a suicide.

Potpourri

**Jim Lumeng**, St. Francis Hosp. pathologist sends us this item which he gleaned from *Clinical Chemistry* Nov. 8, 1978: "Government In Action: If Bureaucratese Invades the Home . . . What would happen if the language of government were applied to the household, if it literally came into every living room? This is the way things might be renamed:

- Living room: recreational and social interaction unit
- Bathroom: human waste elimination and personal hygiene facility
- Kitchen: culinary implementation center
- Guestroom: short-term, non-resident accommodations
- Stairs: semi-vertical, multi-level walkway connectors
- Garage: motor vehicle lodging and repair facility
- Attic: under-utilized equipment storage center
- Refrigerator: multi-use heat-inhibiting edible-provisions unit
- Dog house: external canine housing facility
- Electric toothbrush: energy assisted oral maintenance equipment

(Ed: *bureaucratese is not confined to bureaucrats*)"

Our "Angels"

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**Note: M—AMA Member; N—Nonmember**

**00P1 Basic Electrocardiography—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Principles underlying the genesis of the electrocardiogram will be given. The normal electrocardiogram will be reviewed in the context of the basic principles. The role of computers in electrocardiography will be discussed. At the end of the course, participants should be able to recognize the following: atrial and ventricular hypertrophy, myocardial infarction, pre-excitation syndrome and bundle branch block. The course is designed for persons with a limited background in electrocardiography. **Course Director:** Michael Bilitch, MD—Los Angeles.

**00P2 Office Dermatology—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will present practical pointers and other pearls to aid the practitioner in his management of skin problems. California and Hawaiian clinicians and teachers will share their thoughts and experiences with you. Dermatology from Acne to Zoster will be covered with emphasis on skin cancer (diagnosis, prevention and treatment), contact dermatitis and other allergies, psoriasis, herpes simplex, neurodermatitis and fungal infections. The wiki-wiki (hurry-hurry) rounds will present rapid fire answers to your diagnostic and therapeutic questions. **Course Director:** Norman Goldstein, MD—Honolulu.

**00P3 Pulmonary Disease Update—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • This course will be directed to the practicing physician. Topics to be presented include interstitial pneumonitis and pulmonary fibrosis, current therapy of asthma, sleep apnea syndrome, and the use of the ventilator in respiratory failure. In addition to didactic presentations, there will be a one-hour panel discussion of illustrative case material. The program will be kept sufficiently informal to allow free dialog and questions to the

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### Special Activities:

The Hawaii Medical Association will hold an opening Welcome and Cocktail Reception in the Pacific Ballroom of the Ilikai Hotel on Monday, October 8 from 5 to 7 p.m. Golf enthusiasts may sign up for the HMA Golf Tournament scheduled for Thursday, October 11. Thursday evening you may wish to join in the Sportsmen's Night Dinner at the Japanese Kanraku Tea House. The Hawaii Medical Association Annual Banquet will be held Friday evening, October 12, at the Ilikai Hotel, in the Pacific Ballroom. Details on these special activities and reservations may be obtained from the Registration Desk at the Ilikai Hotel, or by direct correspondence with the Hawaii Medical Association, 320 Ward Avenue, Honolulu, Hawaii 96814.

faculty. **Faculty:** Bruce A. Soll, MD, Course Director—Honolulu; Richard Winterbauer, MD—Seattle; and Clifford Zwillich, MD—Denver.

**00P4 Psychotropic Drugs: Present Uses, Present Problems—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Four major topical areas will be covered: antipsychotic drugs; antidepressants; antianxiety agents; and lithium. Emphasis on each area will be to enhance the practitioner's understanding of the pharmacologic principles underlying the proper clinical use of psychotropic drugs. Each faculty member will present views regarding the use of each of these drugs, affording a greater spectrum of opinion. A considerable amount of time has been scheduled for discussion and questions involving the faculty and audience. The goal will be to assist the primary care physician as well as the specialist in using these drugs effectively and safely. **Faculty:** Leo Hollister, MD, Course Director—Palo Alto, Calif.; and Joe Tupin, MD—Davis, Calif.

**00P5 Management of Hypertension—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Correct concepts in the diagnosis, pathophysiology, and therapy of hypertension will be reviewed with special emphasis on recent developments of significance and applicability to the physician in practice. Use of beta-adrenergic blockade and angiotension conversion inhibition will be discussed. **Course Director:** Dennis R. Meyer, MD—Honolulu.

**00P6 Backache (Video Clinic)—Mon., Oct. 8—8:00 AM-12:00 Noon (4 hours: M-\$30; N-\$40)** • Objective of this videotape course is to review etiology and to teach the newest concepts in diagnosis and management of major entities causing low back pain, including demonstration of diagnostic and management techniques. At the conclusion of the Clinic, the physician should be able to perform an accurate differential diagnosis; determine which cases require specialty consultation; and administer appropriate nonsurgical treatment. **Course Director:** Edgar C. Dawson, MD, Division of Orthopaedic Surgery, School of Medicine, University of California—Los Angeles.

**00P7 Cardiac Arrhythmias—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • The anatomic and electrophysiologic basis of cardiac arrhythmias will be reviewed. Normal impulse formation and conduction will be described. Diagnostic modalities including the electrocardiogram, Holter monitoring, stress testing and intracardiac stimu-



lation (His Bundle studies) will be discussed. At the end of the course, participants should be able to recognize the following: atrial arrhythmias (flutter, fibrillation, tachycardia), ventricular arrhythmias (extrasystole, tachycardia, fibrillation), sino-atrial disease (sinus arrest and sick sinus syndrome) and atrioventricular block. The course is designed for persons with a limited background in arrhythmias; they should have a working knowledge of the electrocardiogram. **Course Director:** Michael Bilitch, MD—Los Angeles.

**00P8 Office Gynecology—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Directed to the primary care physician, with some discussion of office records and notes, program will discuss common problems seen in the office. Topics will include dysfunctional and menopausal bleeding; colposcopy and cryosurgery; contraceptives and ambulatory office surgery and office sterilization. Lectures will also discuss urethral lesions, vulvitis and vaginitis, routine examination of the breasts, and thoughts on second opinions and unnecessary hysterectomies. Time allowed for question and answer session. **Faculty:** Joseph H. Pratt, MD, Course Director—Rochester, MN; Purvis Martin, MD—San Diego, CA; and William Russell, MD—Phoenix, AZ.

**00P9 Rational Use of Antimicrobials—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will address sensitivity testing techniques, factors that influence patients' responses to antibiotics, and the newer cephalosporins, aminoglycosides, and penicillins. Using this information, physicians will be better able to select an antibiotic for use in serious infections such as pneumonia, bacteremia, endocarditis, and meningitis. Lectures, discussion groups, and case histories will be used. **Faculty:** To be announced.

**0P10 Thyroid Disease—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Applications of thyroid function tests to diagnosis of thyroid disease are emphasized. Case presentations illustrating diagnosis, management, and care of patients with hyperthyroidism, hypothyroidism, thyroid nodules, and thyroiditis will include suitable periods for open discussion, questions, and answers. **Course Director:** Ralph M. Beddow, MD—Honolulu.

**0P11 Fluid and Electrolyte Balance—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will be divided into basic physiology of fluid and electrolyte imbalance as well as acid base balance with in-depth discussion of cases illustrating abnormal physiology. Sodium and potassium metabolism as well as metabolic acidosis and metabolic alkalosis with respiratory compensation will be the topic of discussion. Emphasis will be on a practical approach to the management of these difficult problems in clinical medicine. In addition to demonstrating methods of accurate diagnoses of fluid and electrolyte and acid base problems, appropriate management will be discussed. **Faculty:** Dudley S. J. Seto, MD, Course Director; Robert S. Morrison, MD; and David C. Yuan, MD—Honolulu.

**0P12 Practical Rheumatology (Video Clinic)—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$35; N-\$47.50)** • Course will review diagnostic techniques and teach the newest concepts in the management of rheumatic diseases. Upon completion of the Clinic, the physician should be able to perform an accurate differential diagnosis; identify and treat ten manifestations of soft tissue rheumatism; describe the typical distribution pattern of rheumatoid arthritis and the problems associated with its management; and be familiar with all treatment of chronic rheumatic diseases. **Course**

**Director:** Rodney Bluestone, MD, MRCP, Dept. of Medicine, School of Medicine, Univ. of California—Los Angeles.

**0P13 Common Neurological Problems and Their Treatment—Wed., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course is oriented toward the practical aspects of neurological diagnosis and therapy that can make a difference in your patients. Special attention will focus on the neurological screening history and examination, and the major clinical categories of neurological disease: headache, stroke, coma, and other treatable neurological diseases. **Faculty:** James Austin, MD, Course Director; Stuart Schneck, MD; and Philip Yamell, MD—Denver.

**0P14 Chronic Pain Management—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will deal with the causes, diagnosis, and management of chronic pain conditions. The role of various treatment modalities for chronic pain will be critically discussed. These will include the place of medications in pain control, and also the management of medication abuse in the chronic pain patient, behavioral strategies for dealing with chronic pain, and a critical discussion of some of the more innovative treatments for pain, such as transcutaneous stimulation, acupuncture, biofeedback, etc. **Faculty:** Terence M. Murphy, MD, Course Director; Edmond Charlton, MD; and Wilbert Fordyce, PhD—Seattle.

**0P15 Diagnostic Imaging of the Chest & Abdomen—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course is oriented to the relationships between ultrasound, nuclear medicine, and computed tomography in diagnosis of conditions of the chest and abdomen. Comparison of the various modalities will be made, stressing understanding of protocols related to diagnostic problems. Program is aimed at the general practitioner, internist, and surgeon rather than the expert in diagnostic imaging. Often, the attending physician is confused with the multiplicity of imaging modalities available, and we will attempt to demonstrate a logical approach to common diagnostic problems using these three imaging methods. **Faculty:** Richard D. Moore, MD, Course Director—Honolulu; and L. Rosenthal, MD—Montreal.

**0P17 Diagnostic Procedures for the Acute Cardiac Patient—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • The course will deal with the limits and capabilities of the new diagnostic procedures for cardiac disease. Included will be discussion of cardiac x-rays, use of scanning after injection of gallium 67 and technetium 99m, testing with the treadmill, echocardiography, and other ancillary methods of identifying heart pathology. The course will deal with the most prevalent types of disease, their recognition and guides to appropriate therapy. **Faculty:** Danelo Canete, MD, Course Director; Vincent Friedwald, MD; Eugene Magnier, MD; and Maurice Reeder, MD—Honolulu.

**0P18 Vulvovaginal Problems (Video Clinic)—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$35; N-\$47.50)** • Objective of this videotape program is to review the problems of the vulva and vagina and to teach the newest concepts in differential diagnosis and management of nonvenereal and venereal infections seen in office practice, stressing recognition of masquerading or underlying neoplasia. **Course Director:** Thomas B. Lebherz, MD, Department of Obstetrics and Gynecology, School of Medicine, University of California—Los Angeles.



**0P19 Mass Media Seminar—Tues., Oct. 9—8:00 AM-4:00 PM & Wed., Oct. 10—9:00 AM-12:00 Noon (11-hour, 2-day course: M-\$130; N-\$195)** • This course is designed for official spokespeople who represent their medical organization in print and broadcast interview situations and who officially commit their organization to the news record. Interview situations are videotaped and evaluated by expert faculty. This is a one and-a-half day seminar. **Course Director:** Mort Enright, MAT, AMA-Chicago. (NOTE: This course conveys Category 2 credit.)

**0P20 Perspectives in Immunology 1979—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will provide a current updating in selected topics in basic and applied clinical immunology. Recent knowledge of the cellular and molecular events of the primary and secondary immune response will be discussed. New information regarding the pathogenesis of autoimmune diseases such as lupus erythematosus and rheumatoid arthritis will be presented in terms of differential primary diagnosis and evaluation of disease activity. On completing the course, the practitioner will be able to explain basic mechanisms of immune responsiveness, the pathogenesis of immunologic injury, and select the laboratory tests appropriate to the differential diagnosis of immunologic diseases. **Course Director:** Ernest S. Tucker, III, MD—La Jolla, Calif.

**0P21 The Acute Surgical Abdomen—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Inflammatory lesions, including perforations; intestinal obstruction; vascular catastrophies and abdominal trauma may produce "the acute surgical abdomen." Delays in diagnosis and management may be disastrous as the patient's condition may deteriorate rapidly without timely and appropriate management. The objectives of this workshop are aimed at primary care physicians to whom the initial evaluation of such patients falls. **Faculty:** Thomas J. Whelan, Jr., MD, Course Director; J. Judson McNamara, MD—Honolulu; Leonard Rosoff, MD—Los Angeles; and James Carrico, MD—Seattle.

**0P22 Anemias Update 1979—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will review and discuss the new techniques for diagnosing the various etiologies of anemia. Topics will include the hemolytic anemias, refractory anemias, and megaloblastic anemias. Time allowed for panel discussion and question-and-answer session with the faculty. **Course Director:** Christian L. Gulbrandsen, MD—Honolulu.

**0P23 Office Gynecology—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Repeat of Course 00P8.

**0P24 Office Dermatology—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Repeat of Course 00P2.

**0P25 The Comatose Patient (Video Clinic)—Thurs., Oct. 11—8:00 AM-11:00 AM (3 hours: M-\$25; N-\$32.50)** • This videotape course, directed to the primary care physician, will present a procedure-oriented approach to the comatose patient. It demonstrates the evaluation, initial therapy, differential diagnosis, physical examination and laboratory studies as applied to several causes of unconsciousness including drug overdose, concussion, diabetes, intracerebral hemorrhage, stroke, Stokes-Adams attack, psychiatric causes, and alcohol withdrawal. **Course Direc-**

**tor:** Marie Silver, MD, Department of Emergency Medicine, School of Medicine, University of California—Los Angeles.

**0P26 Practice Management—Managing the Business Side—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course is designed to help improve your appointment scheduling, increase collections, aid in facility design, develop effective personnel policies, and reduce paperwork. You will learn time-saving medical management techniques. Lectures, visuals, and discussion—with time for questions and answers—are combined to increase management skills and efficiency. Designed for established physicians in solo practice or group practice, the course has also proved beneficial to young physicians entering practice. **Course Director:** Jack Walsdorf—AMA-Chicago.

**0P27 New Horizons in Pediatrics—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • This workshop is designed to provide the practicing pediatrician or primary care physician with an in-depth view of new developments in diagnosis, assessment, and management of pediatric patients with particular emphasis on hematology, infectious diseases, allergies, and newborn medicine. Time allowed for question-and-answer session with faculty members. **Faculty:** Raul Rudoy, MD, Course Director; Rodney Boychuck, MD; Stuart Rusnak, MD—Honolulu; and Irving Shulman, MD—Stanford, CA.

**0P28 The Eye and You—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • This course is designed to update the non-ophthalmologist in the latest developments in ophthalmology. Special emphasis will also be placed on giving the primary care physician advice on when to refer a patient and what results can be expected from treatment. Specific topics to be covered will include: glaucoma, intraocular lenses, amblyopia and strabismus, vitreous and laser treatment, indications and results. **Faculty:** Malcolm R. Ing, MD, Course Director—Honolulu; Blaine S. Boyden, MD—San Francisco; and Robert E. Christensen, MD—Los Angeles.

**0P29 Common Gastrointestinal Disorders—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • This clinically-oriented course is designed to provide current information on the most common problems encountered in the gastrointestinal tract. Areas to be covered will include esophagitis, peptic ulcer disease, inflammatory bowel disease, gallstones, pancreatitis, and hepatitis, and chronic liver disease. **Faculty:** Gary A. Globber, MD, Course Director; Harold Conn, MD; and Jon Isenberg, MD—Honolulu.

**0P30 Diabetes: Practical Aspects—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • This course is designed to provide the practicing physician with an update regarding the diagnosis and treatment of diabetes mellitus. It will emphasize office practice and will include the importance of patient education, diet therapy as well as the prevention and management of diabetic complications. The principles of insulin therapy will be emphasized both in the outpatient management of diabetes mellitus and for its acute metabolic complications. An informal question and answer session will follow the formal presentations. **Course Director:** Max Botticelli, MD—Honolulu.

**0P31 Neurological Examination (Video Clinic)—Fri., Oct. 12—8:00 AM-3:00 PM (6 hours: M-\$40; N-\$55)** • This videotape course will review the neurological examina-

tion and demonstrate procedures at the patient's bedside as part of the general assessment of the patient. The course will teach techniques, discuss the purpose of each part of the examination and show patients with relevant problems. **Course Director:** Howard Barrows, MD, Department of Neurology, McMaster University, Health Sciences Centre, Hamilton, Ontario.

**SPECIAL NOTE:** The foregoing information is at variance with our "AMA Continuing Medical Education Catalog." **This** information is the latest, corrected line-up of Honolulu CME course numbers, titles, dates, hours, credits, and prices.

HOTEL RESERVATION REQUEST

AMA Regional Meeting  
Ililikai Hotel/Honolulu, Hawaii  
October 8-12, 1979

**Note:** September 30, 1979 is the last date that rooms are being held for this meeting. After this cut-off date, reservations will be accepted only if rooms are available. A one night's room deposit is required with this form. Please make check payable to the Ililikai Hotel. Please Print.

Name(s) \_\_\_\_\_  
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Total number in party \_\_\_\_\_

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	Deluxe Tower Ocean View (Daily, plus 4% Hawaii State Tax)	Single	\$59
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Deposit of \$ \_\_\_\_\_ is enclosed.  
Arrival Date \_\_\_\_\_ Time \_\_\_\_\_  
Departure Date \_\_\_\_\_ Time \_\_\_\_\_

Return this form with deposit by September 30 to: **Room Reservations Department  
The Ililikai Hotel  
1777 Ala Moana Boulevard  
Honolulu, Hawaii 96815**

**REGISTER EARLY!**  
Use the coupon shown to make your course selections. We'll confirm your enrollment immediately. Your tickets and course registration materials will be sent to you on Sept. 12, 1979. Requests for course tickets received after this date will be held for you at the AMA-CME Registration Desk at the Ililikai Hotel. If the minimum course registration for your first choice is not attained, or if the course is fully subscribed, one of your alternate choices will be substituted. Course sizes are limited—register early. Please make your hotel reservations on the form provided for that purpose. **NOTE:** Breakfast and coffee breaks will be provided for all meeting participants each day.

Honolulu Course Registration

Please return to: **AMA Department of Meeting Services  
535 North Dearborn Street  
Chicago, Illinois 60610  
Phone Inquiries: (312) 751-6503**

**Please note:** The course registration fee for nonmember physicians is approximately 50% higher than the fee for AMA members. Medical student members of the AMA and student nonmembers will be admitted to courses at no fee on a space available basis one hour prior to course sessions; however, nonmember medical students must pay a \$15.00 gate fee. A 50% discount on course fees is given to retired physicians and physicians in postgraduate years 1 through 6 based on current status as physician member or nonmember. **Payment must accompany choice of course(s) requested on this registration coupon.**

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4 ☐ Allied Health 5 ☐ Other

Date	Course No 1st Choice	Fee	Course No 2nd Choice	Office Use Only Ticket No
Monday October 8, 1979				
Tuesday, October 9, 1979				
Wednesday, October 10, 1979				
Thursday, October 11, 1979				
Friday, October 12, 1979				

HAWAII MEDICAL ASSOCIATION CONVENTION REGISTRATION FEE*	\$25.00
TOTAL COURSE FEE REMITTANCE	\$ _____
GRAND TOTAL	\$ _____

NOTE: All courses are five-hour, one-day courses with the exception of Course OP19, which is an 11-hour, two-day course.  
\*A \$25.00 convention registration fee is required of all physicians not members of the Hawaii Medical Association.

**HMA House of Delegates Annual Meeting**  
Monday, October 8, 1979, 1:30 PM  
Opening Session: Reference Committee Hearings  
Guest: Hoyt D. Gardner, M.D., AMA President  
Wednesday, October 10, 1979, 1:30 PM  
Final Session

**Hawaii Thoracic Society Annual Meeting,**  
Monday, October 8, 1979, 7:00 PM and  
**Fireside Chat Conference, Cat. I, 2 hours,**  
7:30 PM  
Contact: R. Respicio, 537-5966

**Special Seminar on Skin Cancer, Monday,**  
October 8, 1979, 7:30 PM  
**Special Medical Collection Management Course**

This course for Medical Assistants will be conducted on Tuesday, October 9, 1979, 1:00 PM by AMA practice management staff.  
The same course will be presented on Wednesday afternoon, October 10 at the Maui Palms Hotel in Kahului for Maui County medical assistants. Send \$25 course registration fee in advance to Bureau of Medical Economics, 111 North King Street, Suite 309, Honolulu 96817; attention Harold Yamaguchi.



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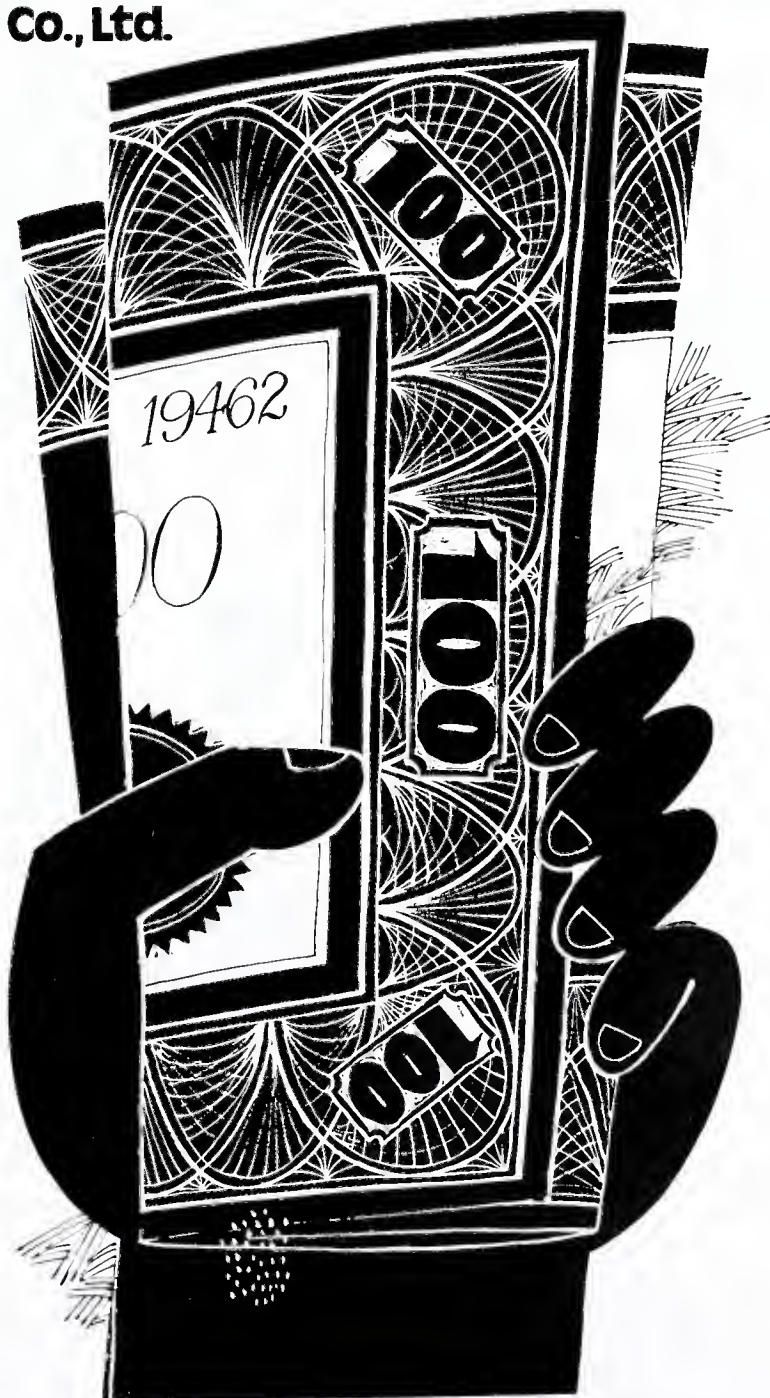
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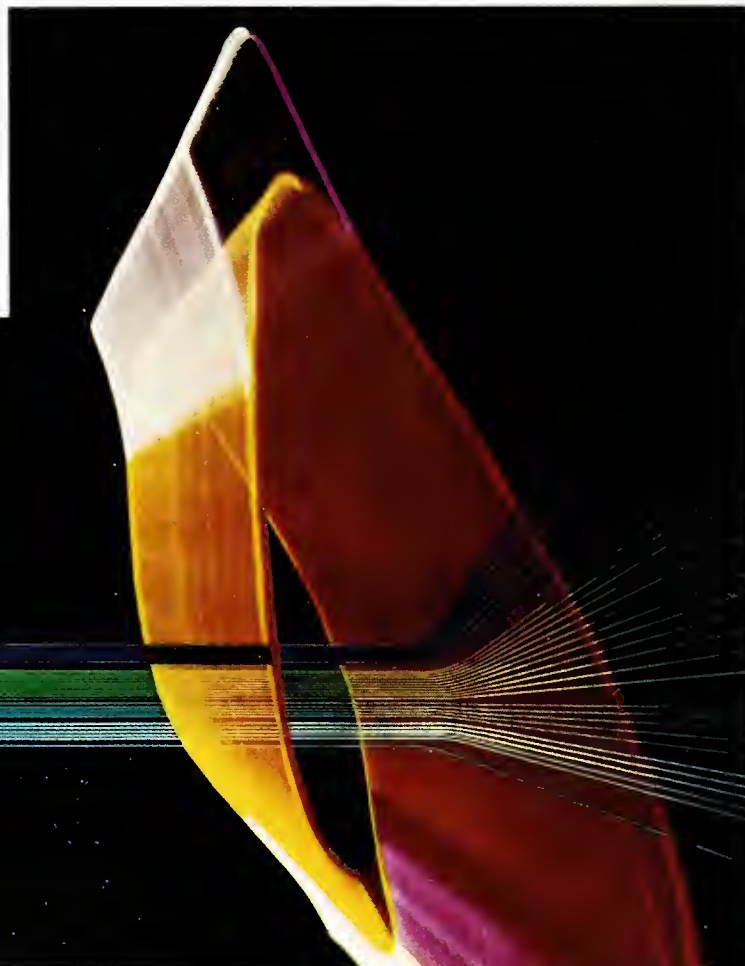
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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants

may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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## Combined Hawaii Medical Association 123rd Annual Meeting

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# The Maker

## Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally “expensive” and generic versions are relatively “cheap.” To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



*MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.*

**FACT:** The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

*MYTH: Industry favors only “expensive” brand names and denigrates all generics.*

**FACT:** PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



# Matters.

**MYTH:** Generic options always exist.

**FACT:** About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for every 45 percent of such expenditure, is a generic prescribing option available.

**MYTH:** Generic prescriptions are filled with expensive generics, thus saving consumers large sums of money.

**FACT:** Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from the same well-known and trusted sources, in the best interest of patients. In most cases the patient receives the same proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

**MYTH:** Drugs account for a major portion of the rise in health care costs.

**FACT:** Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

**MYTH:** Government intrusions into the marketplace will save tax money.

**FACT:** Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

## The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

## The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

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[102175]

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# First Bone Marrow Transplant For Leukemia in Hawaii

ROBERT T. S. JIM, M.D., LIVINGSTON M. F. WONG, M.D., YOUNG K. PAIK, M.D., WILLIAM K. K. LAU, M.D., and ESTHER F. LAU, R.N., *Honolulu*

• *Bone marrow transplantation (BMT) for acute myeloid leukemia (AML) offers the potential for cure. The following report of the first BMT performed for AML in Hawaii is presented.*

## Case Report

J. K. is a 26-year-old Japanese body-and-fender repairman who developed epigastric distress, mild G.I. bleeding, and fever in October, 1978. He was seen by Dr. Gerald A. Hiatt, gastro-enterologist at the Fronk Clinic, where G.I. series, gastroscopy and biopsy revealed duodenitis. Because of blastcells in his blood smear, he was referred for hematologic evaluation.

Past history revealed asthma for many years and tonsillectomy in childhood. Family history included maternal grandmother who had had cancer, type unknown, and a maternal aunt who had died of breast cancer. On 10/31/78, physical examination revealed slight obesity, pallor, mild gum hypertrophy, a grade 2/6 systolic ejection murmur at the left sternal border, liver edge palpable, no spleen or lymph nodes felt. CBC: RBC 2.97 million; Hb 10.3 gm.; WBC 18,100; differential: segs 4, bands 17, metamyelocytes 9, myelocytes 4, promyelocytes 2, myeloblasts 51, lymphocytes 10, monocytes 3 per cent; anisopoikilocytosis, Pelger-Huett anomaly and Auer rods were present; platelet count 48,000; retic count 0.4 per cent. SMA-12 was normal, except for slight elevation of the alkaline phosphatase. Leucocyte alkaline phosphatase was 15 units (normal 15-70); stool and blood cultures negative; VDRL negative; sputa smears and cultures negative for AFB; hepatitis B surface antigen negative; hepatitis B surface antibody positive; Monospot test negative; hemoglobin elec-

trophoresis normal with slight elevation of fetal hemoglobin; normal serum protein electrophoresis; serum ferritin 1568 (normal 12-250); urine muramidase 0.4 mcg/ml (normal under 2); serum muramidase 10 mcg/ml (normal 2-8). Chest x-ray was normal. Liver and spleen scans showed slight to moderate hepatosplenomegaly. Gallium scan showed slight uptake at the peripheral right and left lung fields.

Posterior iliac crest bone marrow aspiration and biopsy revealed a hypercellular marrow with the following differential: bands 12, metamyelocytes 6, myelocytes 12, myeloblasts 56, lymphocytes 7, pro-monocytes 2, monocytes 3 per cent. Megakaryocytes were reduced. On bone marrow chromosomal analysis, there was missing Y chromosome with translocation of approximately 50 per cent of the long arm of chromosome number 8 to the long arm of chromosome 21 (45, X, 8q-, +t [8q,21q]/46, XY). No Philadelphia chromosome was present. Culture of the marrow was negative for AFB and other organisms.

On 11/2/78 he was given cyclophosphamide 200 mg, cytosine Arabinoside 200 mg I.V. (continuous 24 hour infusion) and prednisone 80 mg oral for 5 days and 2 mg Vincristine I.V. single dose. Between 11/19 and 12/1/78 he was given Busulfan (myleran) 4 mg a day. Between 12/7 and 12/20/78, he was given total dose of Oncovin 7 mg and Adriamycin 75 mg I.V. On bone marrow examination 12/27/78, a normal cellular marrow with 5 percent myeloblasts and erythroid hyperplasia was seen. CBC on 1/4/79: Hb 12.3 gm; WBC 3300; platelet count 225,000; with segs 25, bands 5, lymphs 52, mon 16, metamyelocytes 2 per cent.

Pretransplant evaluation included HLA typing, MLC (mixed leukocyte culture) of all family members to select potential BMT donors.

Patient was admitted into protective isolation at Saint Francis Hospital for bone marrow transplantation. Induction therapy included sulfamethoxazole-trimethoprim, allopurinol, high-dose cyclophosphamide chemotherapy, prophylactic oral non-absorbable antibiotics (Nystatin, Vancomycin, Polymyxin B) and total body irradiation at the Queen's Medical Center.

On 1/5/79, he was given cyclophosphamide 4.8 gm I.V., and another 4.8 gm on 1/6/79. On 1/9/79, he was given 1,000 rads total body irradiation. On 1/10, he was given approximately 900 cc of marrow cells from his HLA-identical and MLC-compatible 27-year-old brother ( $2.8 \times 10^8$  bone marrow stem cells), and on 1/11, approximately 800 cc of marrow cells from the same donor. Oral methotrexate 20 mg a day was given on Jan. 12, 14, 22, 29 and Feb 18. Following BMT, his WBC dropped to less than 100 for 12-14 days, hemoglobin to 9.2 gm and platelet count to 10,000. He developed only minimal nausea, anorexia, petechiae, and mild cellulitis of the left arm, controlled with I.V. antibiotics. He was given fresh platelets collected with an Aminco blood cell separator from his donor brother, mother, and random donors on 16 different occasions; the last infusion being on 2/9/79. He was given 2 units washed packed RBC's on 1/26/79. Since then, his WBC has risen to 4700, HG to 11.5 gm. and platelet count to 54,000 by 2/22; with segs 50, bands 1, lymphs 22, monocytes 16, eos 11 per cent. Five bone marrow exams at weekly intervals, since 1/19, showed beginning marrow engraftment by the 10th day post BMT and by 2/8 almost normal marrow cellularity with active hematopoiesis, many megakaryocytes, and no evidence for recurrence of leukemia. During the 7th week post-BMT, however, he developed interstitial pneumonitis.

### Discussion

Despite more effective chemotherapy regimens, improved remission rates and longer survivals for acute myeloid leukemia, the long term survival is still poor. Until recently, BMT has been attempted mainly for advanced or terminal,

chemotherapy resistant AML patients. The survival for most of these patients even with BMT has been disappointing, the 6-to-8 year survival being only 11.8 per cent.<sup>1</sup> Earlier BMT is currently being attempted, the rationale being better clinical status of the patient, less complicating bleeding and infection, a smaller leukemic burden to eradicate and less resistance of the leukemic cells to cytotoxic and irradiation eradication. These patients should be better able to tolerate the anti-leukemic and transplantation regimens. In the patient reported herein, the BMT was tolerated very well, he had no serious infectious complications, engraftment was readily accomplished, and graft-vs-host reaction has not supervened. However, he did develop interstitial pneumonitis the 7th week post-BMT. Support requirements for hematologic elements were also minimal. Early BMT for AML should be considered if an identical twin or HLA-matched sibling is available. This may be the treatment of choice, with the potential for cure.

### Summary

The first BMT for AML in Hawaii is reported in a 28-year-old Japanese male. The procedure was tolerated surprisingly well. Early BMT for AML should be considered if a suitable donor is available and may be the treatment of choice for this disease.

### Acknowledgments

Appreciation is expressed to other members of the BMT TEAM who assisted in the procedure: Drs. Glenn Kokame, Richard Pang, Walton Shim, Robert Wilkinson, James Lumeng, Terry Grimm, Joe Wasielewski, Vincent Brown, Carl Boyer, Paul DeMare, Charles Yamashiro, Fong-Liang Fan; Phyllis Tanabe, R.N., Malia Hegland, R.N., the Saint Francis Hospital Oncology Nursing Staff on Sullivan V, the Clinical Laboratory staff, the Social Service, Home Care, and Dietary Departments. Appreciation is also given to Gerald A. Hiatt, M.D., who referred the patient for hematologic evaluation.

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# A New Method of Managing Subjective Tinnitus

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• *Subjective tinnitus is a very common, annoying and persistent symptom seen in an otolaryngological practice. It is associated with practically every known form of ear disease, but can be produced by a great variety of conditions outside of the ear including the brain stem, the cochlear nucleus, midbrain, or auditory cortex. It deserves careful evaluation because it may represent or be associated with serious or life threatening disease.*

In a 1963 survey conducted by the National Institute of Health, it was found that 36 million American adults suffer from tinnitus. Of that number,  $\frac{1}{5}$  or 7.2 million experienced a severe form of tinnitus so annoying that it is debilitating and often times enough to disrupt one's normal pursuits.<sup>1,2</sup> Vernon has estimated that the incidence of tinnitus has increased since 1973 because of the markedly increased incidence of hearing loss since then.

A fortunate few whose tinnitus is due to cerumen impacted against the eardrum, a catarrhal otitis media, fluid in the middle ear, perforation of the eardrum, otosclerosis, and a few other middle ear problems can be relieved by medical and surgical means. However, a great majority of tinnitus cases are not amenable to medical treatment or even to surgical intervention. These patients are usually advised that there is nothing that can be done and that they should learn to "live with their affliction." Most of these patients adjust to their situation, but there are some who are unable to tolerate the noise so that it affects them psychologically and even physically. Some of these desperate cases are even willing to sacrifice their hearing for relief of symptoms.

## Masking Tinnitus

The purpose of this paper is to describe a method for relief of tinnitus originally set up at the Kresge Hearing Institute at the University of

Oregon School of Medicine in Portland, Oregon. The method is based on variations of a single theme of masking.<sup>1,2</sup> By the proper application and control of external sounds introduced into the affected ear, the patient becomes unaware of his tinnitus.

In some cases where there is a hearing loss, a hearing aid is recommended to improve the hearing. This amplifies the environmental noises and thus masks out the tinnitus. In other cases, a masking noise is introduced to the patient's ear by means of a postauricular masking device. In still other cases, a combination of a masking device and a hearing aid known as a tinnitus instrument is used. It was the pleasure and privilege of the senior author and the associated audiologist to visit this clinic. The method we now use in the management of these cases of severe tinnitus is based on the protocol set up at the Kresge Clinic.

A patient complaining of tinnitus should have a thorough examination including a careful history, a complete otoneurological examination, a thorough and complete audiological evaluation, including pure tone and speech audiometry, Bekesy audiometry, impedance audiometry, and any other neuro-otological tests including an electronystagmogram, brain stem audiometry, and x-rays of the petrous pyramids as deemed necessary. Once it has been established that the etiology of the tinnitus is not due to any life threatening or serious problem and that medical and surgical treatment is not feasible, the patient is apprised of his condition.

## Try Simple Measures First

A thorough explanation, together with advice as to how to overcome the tinnitus such as using music at the bedside, the use of static created by setting the dial between FM stations, and other means to detract from the tinnitus is given to the

patient. Often, these simple measures alone will suffice in relieving the patient of his anxiety and make the condition tolerable. However, if the patient is not relieved by this or cannot adjust to the tinnitus, an attempt will be made to relieve the tinnitus.

The first step then consists of matching the tinnitus for its pitch and then measuring its intensity. Once the pitch has been identified and is superimposed upon the ear, the measure of the intensity of the tinnitus is usually obtained at the point where the superimposed sound is heard above the threshold of the fundamental frequency of the tinnitus. This measures the intensity of the tinnitus, and also gives the examiner a point where the superimposed sound will mask out or drown out the tinnitus. Usually this point is from 5-10 dB above the threshold of the hearing loss.

This peculiar phenomenon is based on the observation of Josephson<sup>3</sup> that "when a sound of the same fundamental pitch as the tinnitus is superimposed on the ear, a masking of the superimposed note by the tinnitus is found instead of a summation of intensity." He found that the tinnitus is at the pitch or pitches where the auditory curve drops off sharply. He also found that the tinnitus can be completely drowned out by simultaneously superimposing the pitch of the tinnitus to both ears. If the tinnitus is drowned out, it may be lost for a period of time after the stimulation has stopped. This is now referred to as residual inhibition. He first described this condition in 1931. It was further studied by Feldman<sup>4</sup> in 1969 and 1971, and was independently "discovered" by Jack Vernon in 1976.<sup>1,2</sup> Residual inhibition therefore is defined as a persistence of the masking affect upon the tinnitus after the masking sound has been terminated. The residual inhibition may last for a few seconds to a few minutes but in some cases, it has lasted for hours and lately cases have been noted in which inhibition lasts for days.

### Hearing Aid May Help

The next step involves the use of the appropriate instrument to mask out the tinnitus. One common type of tinnitus is a high-pitched variety which accompanies a high frequency hearing loss. Often, the mere fitting of a proper hearing aid on this type of patient gives relief of the tinnitus. A hearing aid for the relief of tinnitus was first recommended by Saltzman and Ersner<sup>5</sup> in 1947. They felt that by amplification, much outside sound is enabled to reach the cochlea and therefore drown out and mask the patient's tinnitus or head noise. They used this in a number of cases of otosclerosis and found that in improving the hearing, the tinnitus was masked. It has been found, however, that the use of a hearing aid alone will not cause residual inhibition.

In other cases, the hearing loss is near normal or hearing loss is only isolated in high frequen-

cies (above 3000 Hz), with normal hearing in the lower frequencies. A hearing aid is not tolerable in these cases. Instead, use of a tinnitus masker is indicated. The masker, worn like an ear-level hearing aid, produces white noise or a least a broad band noise, which can be altered by opening the tube-fitting so that high frequency sounds are available. These tinnitus maskers come in three forms—low frequency, wide-band, and high frequency.

The intensity level of the tinnitus masker is under the control of the patient. If the patient gets relief from the tinnitus, he is asked to remove it for a period of time to determine if there is any residual inhibition present. Residual inhibition is present in about 78% of the cases, for varying periods of time. When it fails to occur, Vernon<sup>1,2</sup> assumes that this is due to an improper identification of the tinnitus, or that some forms of tinnitus are different and simply do not display residual inhibition. In some cases where there is more substantial hearing loss associated with the tinnitus, the combination of a high frequency hearing aid with a masking device—the tinnitus instrument—is recommended.

To date, we have been able to help most of the cases. Some of the failures are due to: 1) Failure to correctly match the tinnitus because of tinnitus with dual tones or overtones. 2) Tinnitus of such high pitch that it is beyond the range of our present high frequency maskers. (The really high-pitched tinnitus maskers, now being developed should be available for distribution soon.) 3) Psychological difficulty of some individuals to accept the concept of introducing another noise in the ear to overcome the tinnitus.

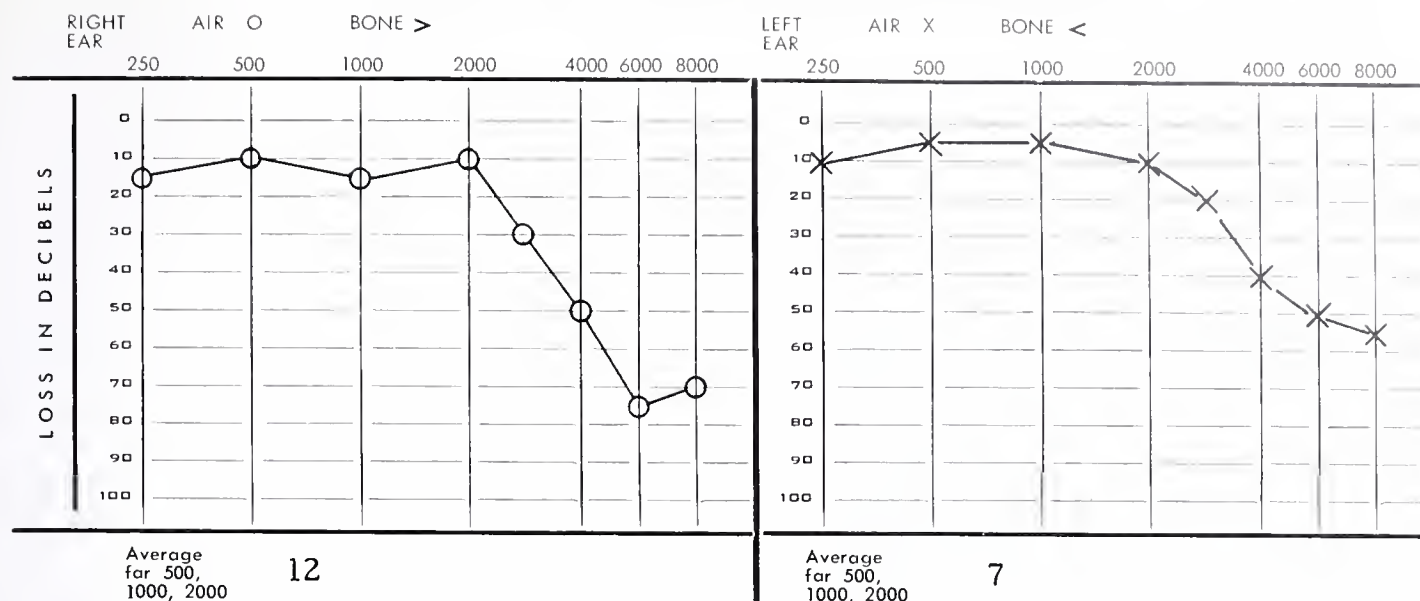
The following are presentations of cases successfully managed in this manner.

### Case Reports

CASE 1: W. T. L. is a 60-year old man originally seen 3 years ago with the complaint of a hissing sound in both ears, more so in the left ear, like "an air hose leaking." Occasionally it appeared to be cycling with 3 days of loud hissing and then a day of some quiet. He gave a history of exposure to artillery fire while he was in the National Guard. Examination of the ear, nose, and throat was essentially negative. Audiometry revealed a moderate high frequency hearing loss in both ears, with normal hearing in the speech frequencies (Fig. 1). Speech audiometry revealed a speech reception threshold of 2 dB in the right ear and 0 dB in the left ear. The speech discrimination score was 90% in both ears. Impedance audiometry was entirely normal. Tinnitus evaluation and matching was performed. He was unable to pinpoint the primary pitch of the tinnitus, but narrowed it between 350-400 Hz. Complete residual inhibition was observed several times during the evaluation. Each time it occurred, it took several minutes for the tinnitus to return to its normal loudness level. At the end of the evalu-



Fig. 1—Audiogram for case 1 showing a moderate high frequency hearing loss.



ation, a wide-band tinnitus masker was selected for the left ear. It was worn with an open acoustic modifier earmold. Following a month's trial with the masker, he reported much improvement in his tinnitus. After 2 weeks of using the masker, he noted that wearing it for 2 days would give him 2 days of temporary relief without the masker. This further improved so that one month after usage, he reported 3-4 hours of wearing the masker would give him several days relief. He is able to sleep well at nights. Occasionally, the tinnitus gets really bad, but the use of the masker would "calm the tinnitus down" so that he can become completely relaxed. *Comment:* This is the most unusual case of residual inhibition that we have seen in our series of cases. He has gone over one year and has complete relief of his symptoms.

CASE 2: M. M. is a 62-year old man with the complaint of a high-pitched tinnitus of the left ear for one month's duration. He stated that it was almost as loud as a civil defense siren and occasionally sounded like a whistle or ringing. He

usually got some relief from the tinnitus on listening to the radio or TV and traffic sounds. He noticed that his hearing was deteriorating since 1972. He has since retired as a construction worker. He was told that there was nothing to be done about the tinnitus by another otolaryngologist. The audiological evaluation revealed a sloping moderately severe sensorineural hearing loss bilaterally (Fig. 2). He had a speech reception threshold of 38 dB in the right ear and 32 dB in the left ear, with speech discrimination scores of 86% and 88% respectively. The tinnitus evaluation placed the primary pitch of the tinnitus at 4000 Hz at 5 dB sensation level. Several tinnitus maskers and high frequency hearing aids were tried. He found the hearing aids to be the most comfortable instrument to listen to. He felt that it also helped his hearing as well as masked out his tinnitus. Upon selection of the hearing aid, he was cautioned that the hearing aid would be effective in masking the tinnitus only as long as there was enough ambient noise present. After a two week trial with the hearing aid, he reported much success with the aid. He felt that it masked

FIG. 2—Audiogram for case 2 showing a moderately severe sensorineural hearing loss bilaterally.

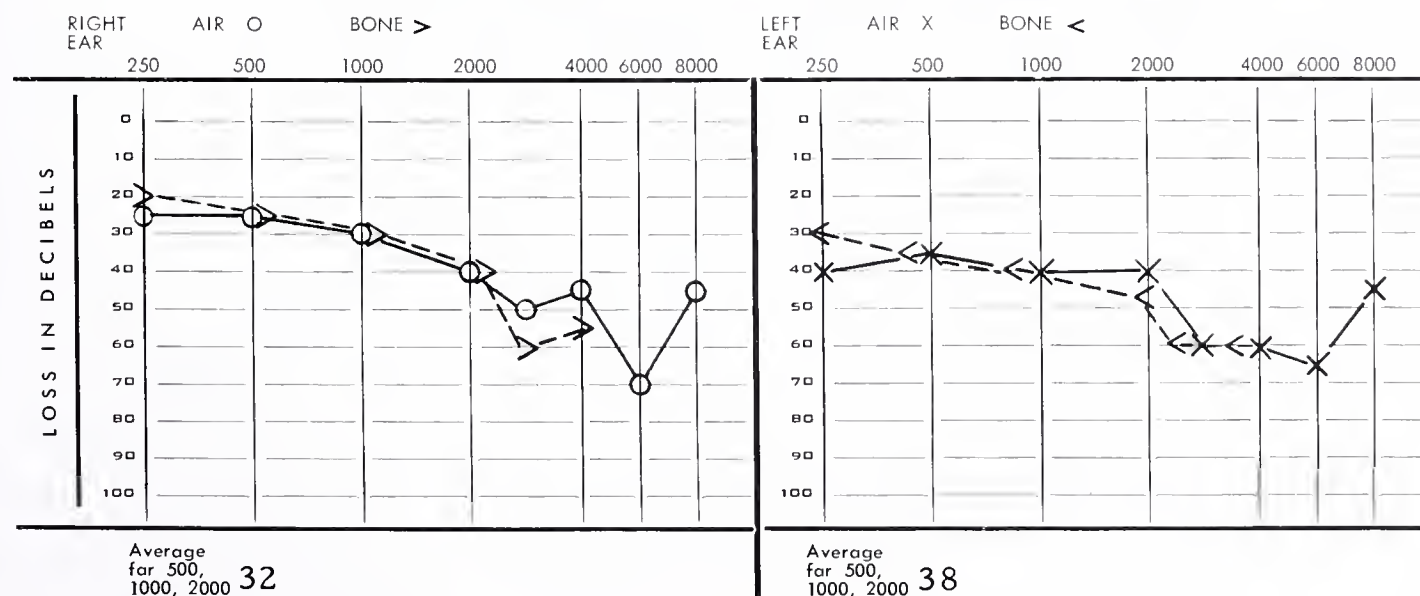
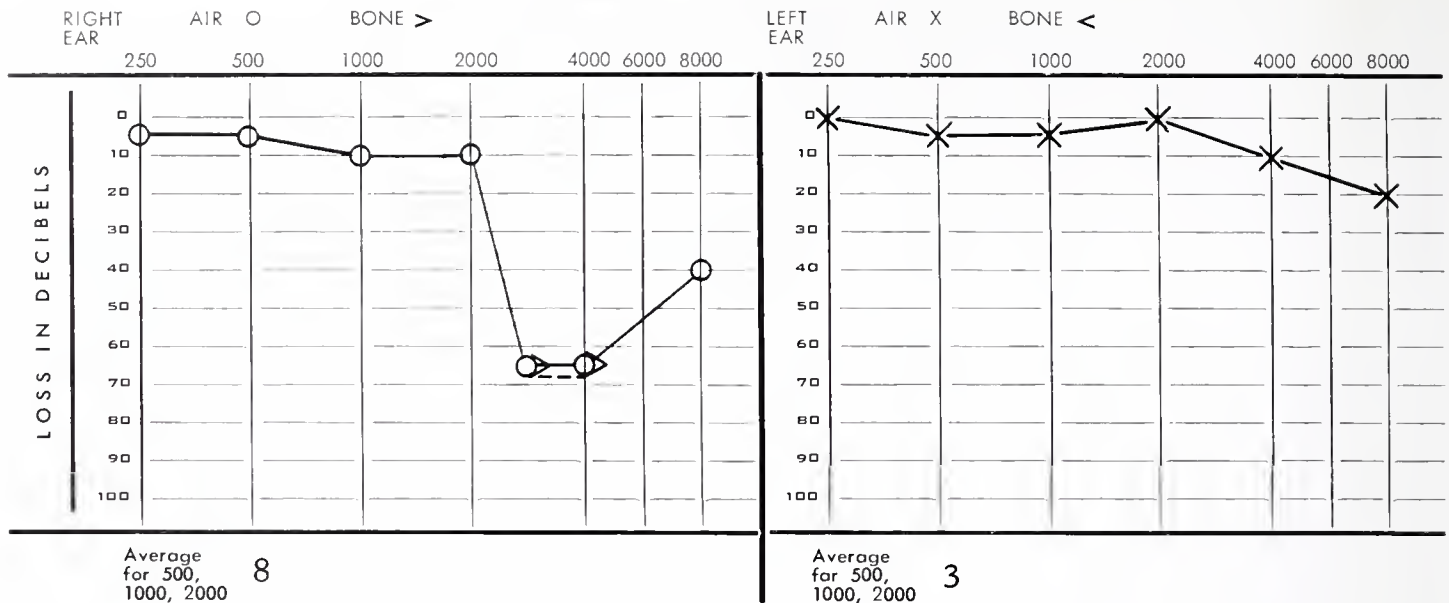


FIG 3—Audiogram for case 3 showing a high frequency loss.



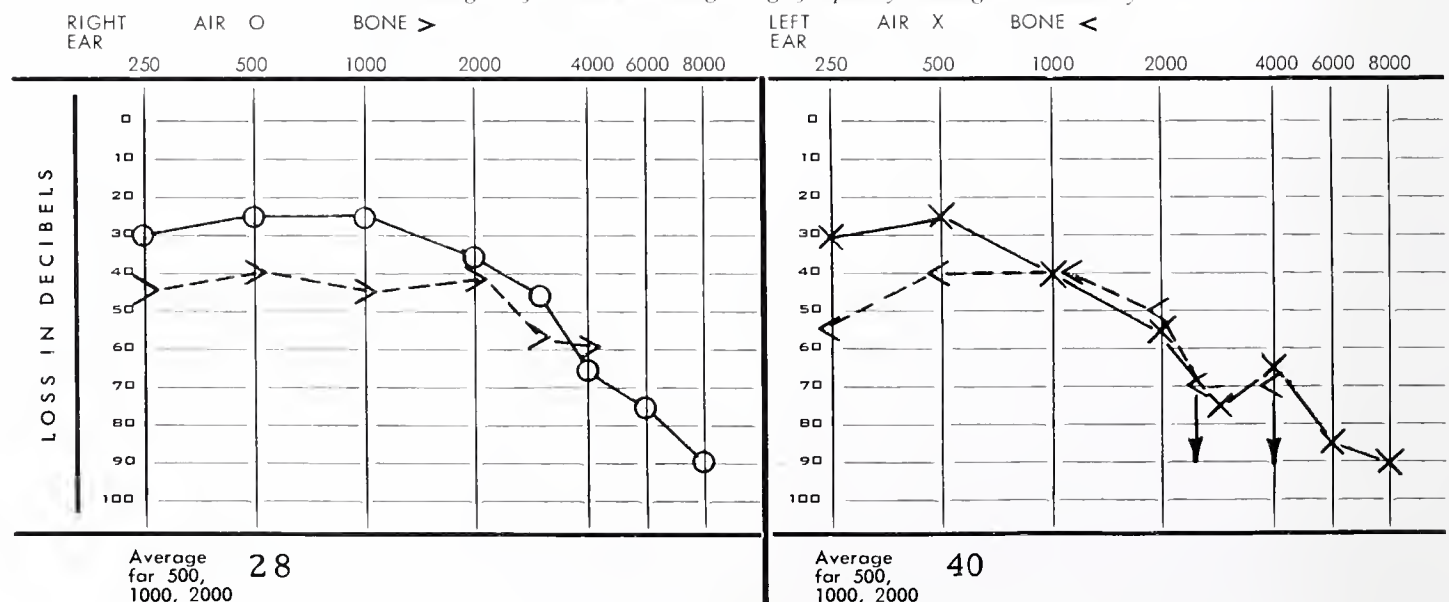
out the tinnitus quite well. He did not however notice any residual inhibition. *Comment:* Vernon has reported that residual inhibition is never seen with the use of hearing aids alone.

CASE 3: W. D. is a 37-year old veteran who has been suffering from a continuous tinnitus in his right ear for 13 years (Fig. 3). He described the tinnitus as a high pitched ringing that is especially irritating when he is in a quiet area, under pressure, and when trying to fall asleep. This is associated with a high frequency hearing loss in his right ear. He attributes his tinnitus and hearing loss to noise trauma while serving as a gunnery officer in the Navy. Occasionally the tinnitus is so loud that it interferes with his sleep. He used to sleep with a radio playing but this annoyed his wife so that he had to discontinue its use. The tinnitus was so annoying that he had been referred to a psychiatrist for psychiatric evaluation and help without relief. In the tinnitus evaluation, the patient selected a combination of 6000 and 8000Hz at 50 dB sensation level to be the primary pitches of his tinnitus. (*Comment:* This is somewhat unusual in that Vernon has

found most of his patients to have tinnitus at only 5-10 dB SL.) High frequency aids were tried following the identification of the pitch, but as expected, they were found to be too irritating to the patient, his hearing being normal in the speech frequencies. The instrument that proved to be most effective was the high frequency tinnitus masker which was recommended for use in the right ear with an open mold. He was seen again several weeks after receiving the masker. He has expressed great satisfaction with it and was wearing it for 24 hours a day. He felt that he slept better and was more alert during the waking hours.

CASE 4: T. C. is a 60-year old heavy equipment operator who had a constant high pitched ringing in both ears, worse in the left ear, associated with a hearing loss for 5 years. He was particularly concerned because, with the tinnitus and the hearing loss, he could not hear the cow bell on the fishing rod when he went fishing. He had worked as a heavy equipment operator for nearly 40 years without any ear protection from the noise. He had seen an otolaryngologist who

FIG 4—Audiogram for case 4 showing a high frequency hearing loss bilaterally.





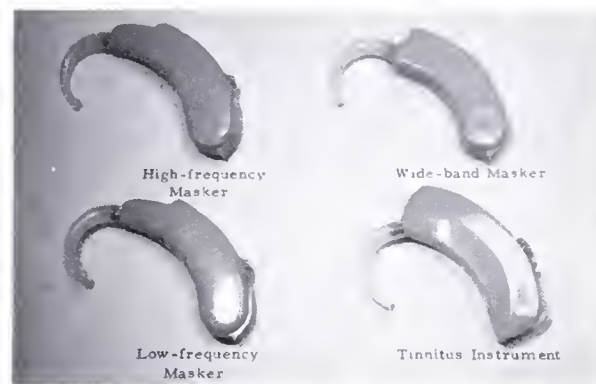
advised him that he had a nerve type of hearing loss and that nothing could be done to improve his hearing and was given some tranquilizers for use. There was no history of head and neck injury but he had had two disc surgeries in the lower back for a job-related injury. An audiological evaluation revealed a high frequency sensorineural hearing loss averaging 28 dB in the right ear and 40 dB in the left ear (Fig. 4). Speech audiometry revealed a speech reception threshold of 18 dB and 40 dB respectively, with a speech discrimination score of 88% in the right ear and 80% in the left. Impedance audiometry was normal. As he wished help for his hearing, a high frequency hearing aid was selected for his left ear. The aid selected also masked out his tinnitus. After a two-week trial, he returned and stated that the hearing aid effectively masked the tinnitus in his left ear and also helped him to hear better. However, the ringing in the right ear had become more apparent now that he was no longer aware of the tinnitus in the left ear. A high frequency hearing aid in the right ear resolved the problem. However, he was reluctant to wear binaural hearing aids and felt that he could "live" with the ringing in the right ear as long as the tinnitus in the left ear was masked out. *Comment:* T. C. is an example of a patient with binaural tinnitus who was not aware of the tinnitus in the right ear because of the severity of the ringing in the left ear. He became aware of it once the tinnitus in the opposite ear was masked out. Vernon found that 58% of his patients had binaural tinnitus. Some patients can be masked monaurally with relief, while others must be masked binaurally for relief.

### Discussion

These case studies presented are examples of those who have been successfully treated by

either the use of a masker, hearing aid, or combination of both (Fig. 5). There have been cases which we have not been able to help. These are patients who have recruitment and very low tolerance to noise, or who have a very high pitched tinnitus beyond the range of the hearing aid or the high frequency tinnitus maskers. The patient

FIG. 5—Tinnitus maskers.



with low tolerance is unable to tolerate the noise of the masker or the extraneous noise generated by the hearing aid and the noise becomes an added irritant. Those with very high frequency tinnitus hopefully can be helped as ultra high frequency masking devices are being developed. The results however are promising.

### Summary

A new method for the relief of annoying and severe tinnitus is presented. It is based on the principle of masking out the extraneous sounds by the use of a hearing aid, a tinnitus masking device, or a combination of both. Several cases successfully managed by this method are presented. The results are promising for those who previously have not had any help from that annoying distressing symptom.

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# Electrical Shock

ALBERT F. LEE, M.D., *Honolulu*

As a young lad, I saw an electrical lineman get a jolt from a transmission line. He got up, dusted himself off with his cap and went back to work. I later saw an electrician wet his fingers to test a 110-volt line to see if it could possibly be a 220-volt line.

In those days, such workers did their testing and working with one hand. They did not allow the current to course through their bodies.

All of this, hopefully, is in the past among workers. However, we now have a group of less knowledgeable folks, including CB'ers, whose antennae may fall across power lines; they add fatalities through their ignorance.

Two 14-year-old lads in Chicago, in 1977, were electrocuted when their CB antenna fell across an electrical transmission line. In Honolulu, we had a similar accident, and within the same month a commercial CB operator was killed, along with a CB installer.

Electrical shock occurs commonly, and yet few physicians become expert in this field; we (fortunately) don't see enough of these cases individually to develop great skill in their care. Included in a discussion of electrical shock should be a few words on lightning, household accidents, hospital electrical devices, and the rare fallen power line. The majority of electrical shock victims are linemen who know better but are careless. Knowledge and experience give no immunity to electrical shock.

## **Resuscitation is Urgent**

Such accidents can tax the skills of the most competent physician or surgeon. The prime physical response to electrical shock is in the respiratory system. After the victim is cleared from his electrical hazard, artificial respiration should be begun after the technique of Schafer, mouth-to-mouth resuscitation, or by anesthesia

(open or closed bag technique of oxygen and CO<sub>2</sub>).

Artificial respiration should be continued almost beyond the hope of recovery. Such treatment, even though it may seem fruitless, is indicated in the hope that the cardiac function will recover (as it often does) and that this will be followed by good respiratory response. Electrical shock very often acts on the heart in the same manner as a defibrillator: cardiac function will usually survive electrical shock—if the jolt isn't too severe.

Modern transmission lines are higher than those of earlier days and they carry greater current. When a person receives electrical shock today from this source, the burns are deeper and the high shocking currents will often pitch the victim some distance. Severe muscular contractions may cause additional injury such as fractures, or rupture of a viscus may result from a fall.

Electrical shock injury is chiefly deep burns to every body system. Nothing is spared, not brain, nor nervous system, heart, eyes, muscles, gastro-intestinal, pulmonary, urological, nor vascular systems. The longer the shocking contact, the deeper the burns.

Late complications from such burns are common and should be anticipated in the hospital whence such victims should be taken.

## **Points in Prevention**

As always, the best approach is prevention. This should include:

1. Turning off all power in the work area when testing or repairing electrical systems.
2. Wearing leather or thick non-conductive gloves in working around electrical power.
3. Working only with one hand—placing the second hand in back of one's belt.



4. Wearing dry socks and heavy non-conductive shoes during work around electricity.
5. Working with a companion who is equally careful and knowledgeable.

Electrical shock does its harm to the human body by coursing current from hand to hand, hand to body, or hand to foot from the live current to ground. All household appliances, hospital electrical devices and systems should be grounded for safety. With the passage of the current through the body, there is harmful effect to the breathing center, the heart, the skin, kidneys and other organs. One should eschew a conductive position.

In electrical shock, it's the amperage that damages and not the voltage. I've heard some bragsters declare that they can take "X" number of amps safely. This may be true, but deaths have been reported with as little as 40 volts, and in certain heart problems, shock may cause death with as little as the current from a 1½ volt battery. (don't take a chance!) However, most deaths result from electrical shock from 110 volts to 250,000 volts.

In Honolulu, electrical workers and ambulance and emergency room crews should know acute care techniques, but safety and prevention are paramount with respect to electrical shock.

*Now alcoholics can continue to work while under treatment . . .*

## An Alcohol Treatment Program for the Employed Person

JOYCE INGRAM-CHINN,\* *Honolulu*

A new alcoholism rehabilitation program has been instituted in Honolulu to help alcoholics overcome their addiction while continuing to work. Called the Life Health Program, it is Hawaii's only rehabilitation program geared entirely to meet the needs and overcome the problems of the working alcoholic.

The program is located on the grounds of The Rehabilitation Hospital of the Pacific, 226 North Kuakini Street, and housed in a detached building behind the hospital, an arrangement that provides the individual patient with both privacy and easy accessibility.

The purpose of the Life Health Program is to offer a safe place for the employee to examine critically the role alcohol plays in his or her life. A treatment plan is developed to help the employee's life become constructive again.

A unique feature of the program is that the employee can participate in the program on either an outpatient or resident basis.

In the outpatient program, the employee continues working during the weekdays and attends therapy sessions on 21 consecutive evenings and weekend days. The evening and weekend schedule provides an accessible and convenient rehabilitation opportunity for the employee.

The resident program is designed for employees who need a change in environment and

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\*Coordinator, Life Health Program, The Rehabilitation Hospital of the Pacific. Accepted for publication May, 1979.

lifestyle to overcome their addiction. Treatments are intensive and last 21 days.

### After-Care Program

The outpatient and resident programs are each followed by a 49-week after-care program designed to meet the individual's needs.

A team of specialists from the program and the hospital supervises and guides the individual through rehabilitation. The team consists of a medical consultant, certified alcoholism counselors, a dietitian and a therapeutic recreation specialist.

The referring health professional can feel confident that the Life Health Program will maintain contact with the client's private physician, according to Tyler M. Harr, one of the program's alcoholism counselors. The physician will be con-

sulted on all medical matters concerning the patient. Our client will remain the physician's patient and, with the client's consent, the physician will be appraised of the client's progress.

### Variety of Methods

The program uses a variety of treatment methods, including group therapy, therapeutic recreation, films and discussions, spirituality workshops, relaxation therapy, educational sessions, nutritional therapy, leisure counseling and individual counseling.

All referrals and admissions into the program are handled on a confidential and personal basis. Interested health professionals are invited to call 536-9246, for more information or to determine if a patient is appropriate for the program.



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*Lydia O'Leary*  
OF HAWAII

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PHONE 949-3288





## Federal Medicine

It's a shame that physicians who are so aware of the limitations of federal medicine, are generally ignored by the dreamers who demand "National Health Insurance" as a solution to the high cost of medical care.

More than any other group, we understand that magnitude of federal medical inefficiency in the Department of Defense and the Veterans Administration. Perhaps there's merit in reminding our patients that "free" fedicare in the service hospitals is not only less pleasant but more expensive, and that the government which can't seem to deliver cost-effective care at Tripler, sure won't be able to run Queen's any better.

If federal medicine really were cheaper and better, we'd have heard all about it: the government's system of hospitals and clinics provides an ideal proving ground for its theories, and a showcase for efficiency and economy. The fact is that the government can't run competitive medical programs, which is why the feds refuse to permit DOD or VA hospitals to submit to PSRO or Utilization Review.

The simple question that The Planners won't answer is, "Since Medicare for the elderly has bankrupt the Social Security System, and Medicaid for the indigent (indolent?) is bankrupting federal and state budgets, how can a scheme to extend these benefits to the whole population be expected to save any money?"

The answer, as we all know, is that such a fiscal about-face is preposterous, since federal services always cost more than private services, and far more than anticipated. The more comprehensive the medical scheme, the faster the costs will zoom: if federal funding now costs X dollars annually for a third of the people, it will cost more than four X dollars for all the people, because of the tremendous overhead related to managing this giant transfer of payments.

Until Kennedy and the other jokers can ex-

plain how we'll save money by spending more of it, we must continue to warn that with progressing national bankruptcy, we simply can't afford to buy a system that's more expensive and wasteful than what we already have. Fortunately, Congress may have already realized this.

Once the national budget is balanced, and the inequities and waste are worked out of our present federal medical programs, we may then begin to consider the purchase of additional options. Actually, until they can get the Postal Service fixed, I'd rather The Planners not fool any further with medical care.

JMC

## Relativity Theory

Physicians continue to complain about the weary old 1970 Hawaii Relative Value Study, grumbling that new procedural codes are needed, while old inequities remain uncorrected. They wonder aloud why we don't make a new one.

Well, we did, of course. The 1976 Hawaii Relative Value Study, the tremendous work of Dr. Maurice Nicholson's Fee Survey Committee, was being readied for the printer when the Federal Trade Commission challenged Relative Value Scales as "constituting illegal price fixing" under the Sherman Antitrust Act. This, of course, is pure nonsense.

Since 1977, the FTC has blocked all attempts by specialty groups and medical societies to publish RVS, forcing consent to "discontinue promulgation or publication of relative value studies, schedules or guides." Failure to heed the agency carries a \$10,000 fine per day!

All efforts by the AMA and others to secure legislation confirming the authority of our profession to develop and use RVS have been to no avail. But the Justice Department lost its recent test suit against the American Society of Anesthesiologists, which had refused to "consent" to the FTC order. Societies which did "consent" remain muzzled, however, until a decision is reached on appeal.

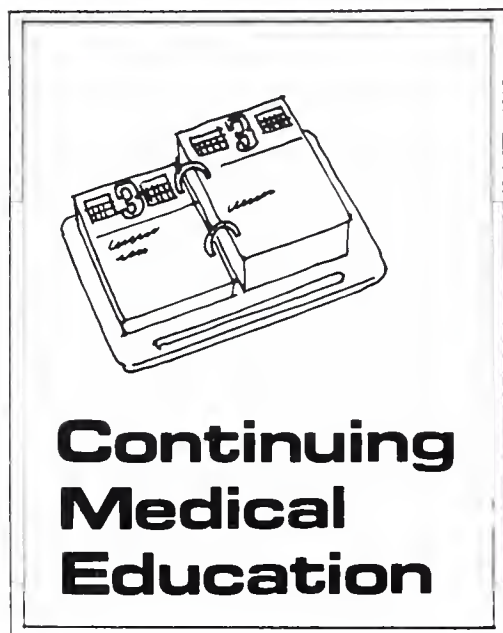
But the Hawaii Medical Association, which did not consent, technically retains a right to publish relativity scales, which the federal judge agreed was "a testament to the need for a cohesive, internally consistent, logical, and appropriate methodology . . ."

Should we publish (and possibly perish), or continue to cautiously await further developments? The mood may be shifting to a bolder position, one of getting on with our necessary business and ignoring the bureaucracy: "Publish and be damned!"

The irony in all this is that government agencies from HEW to DSS freely publish and use all kinds of medical fee schedules because they're

absolutely necessary, and now the feds are proposing national scales. But for physicians to compare the relative complexity of an appendectomy vs. a tonsillectomy is illegal! How can something be at once both legal and illegal? Because government agencies commonly issue contradictory orders these days; it needn't make sense, it's government. You might say that it's all relative.

JMC



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. Dept of Medicine
  - A. Case Conferences, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - B. Grand Rounds, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
  - D. Hematology-Oncology Grand Rounds, First, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
  - E. Cardiology Grand Rounds, Second and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
  - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
2. Division of Nuclear Medicine
  - A. Technical aspects of Nuclear Medicine, Second Tuesday, 5:00-6:30 p.m., Queens University Tower, Room 413, 1½ credits.

- B. Rounds, Fourth Tuesday, 5:00-6:30 p.m., Queens University Tower, Room 413.
3. Dept. of Obstetrics and Gynecology
  - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
  - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
  - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
  - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
6. Dept. of Psychiatry (resumes in September)
  - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
  - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room 11).
7. Dept. of Surgery
  - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
  - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
  - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
  - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.



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- University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., University of Hawaii, Manoa Campus, BioMed Building, Room T-210.
- HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

#### Hawaii Thoracic Society

- Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club, 3rd Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

#### Hickam Clinic

- Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
- Didactic—our staff, 2nd Thursday, 11:00 a.m.
- Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
- Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

#### Hilo Hospital

- Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
- NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
- Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
- Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
- C.P.C., 4th Friday, 12:30-1:30 p.m.
- E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
- Visiting Professor's Program
- Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

#### Kaiser Hospital

- Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.

- Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
  - OB/Ped. Perinatal Mortality Conf. Last Tues. ea month. 8:00 a.m. 1 hr. Cat. I.
  - Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
  - Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

#### Kapiolani-Children's Medical Center

- Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
- Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
- Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
- Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
- Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

#### Kuakini Medical Center

- G.I. Conference, 1st Tuesday, 8:00-9:00 a.m.
- Nephrology Conf., 4th Wednesday, 8:00-9:00 a.m.
- Oncology Conf., every Thurs. 7:30-8:30 a.m.
- Surgical Conf., 1st, 2nd and 3rd Fri., 12:45-1:45 p.m.
- Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 12:45-1:45 p.m.
- Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, 1:00-2:00 p.m.
- Ophthalmology Department Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
- Visiting Professor Lecture.

#### Maui Memorial Hospital

- Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
- Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
- Dept. of Emergency Med., 3rd Mon., 7-8:00 a.m.
- Diagnostic Radiology—4th Tues., 12-1:00 p.m.

#### The Queen's Medical Center

- Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
- Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium  
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium  
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium  
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
- Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Kam Aud.

#### St. Francis Hospital

- Visiting Professor Program
- EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
- Dept. of Med. Monthly Mtg. 2nd Tues. ea month. 7:30 a.m. Sullivan 4-classroom.
- SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. Sullivan 4-classroom.
- SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. Sullivan 4-Classroom.
- SFH-UH Hematology Conf., 3rd Thurs. ea month. 12:30-1:30 p.m. Sullivan 4-Classroom.
- SFH-UH Renal Conf. 1st Monday ea month. 7:30-8:30 a.m. Sullivan 4-Classroom.
- Tumor Conf., ea. Monday, 7:30-8:30 a.m.



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9. SFH-UH Pulmonary Conf. 2nd & 4th Wed. ea. mth. 12:30-1:30 p.m., Sullivan 4-classroom.

#### **Straub Clinic & Hospital**

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

#### **Wahiawa General Hospital**

1. Noon Seminars, Every Tuesday

#### **Wilcox Hospital (Lihue)**

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: I, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

#### **SPECIAL EVENTS**

Sept. 9-17, 1979 Practical Management of Anesthetic Problems, USC Sch of Med., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 31¼ hrs.

Oct. 8, 1979 HI Thoracic Society—Annual Mtg. 7:00 p.m. Fireside Chat, 7:30 p.m. 2 hrs. CME Cat. I—Ilikai Htl. Honolulu. Contact: R. Respicio (808) 537-5966 for further info.

Oct. 8, 12, 1979 123rd Annual Convention-HMA/AMA Regional Mtg. Ilikai Htl. Honolulu. 5 days. Contact: HMA Office (808) 536-7702.

Nov. 19-21, 1979 "Nutrition, Sex and Controversy." 6:30-9:30 p.m. Mon & Tues; 1-4:30 Wed. 10 hrs. Cat. I.

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no fee. Dept. of Ped., John A. Burns and Kapiolani-Children's. Contact: Wilma Schiner, Dir. of Training & Ed. 1319 Punahou St. Honolulu, 96826.

Dec. 1-6, 1979 American Medical Assn.—Interim House of Delegates Meeting  
Robert Hobart, III  
Director, Dept. of Meeting Management  
535 North Dearborn Street  
Chicago, IL 60610  
Hdq. Hotel: S-W  
Agent: Not appointed

Dec. 6-9, 1979 American Medical Joggers Assn.  
Mr. Hugh S. Ames  
Honolulu Marathon Assn.  
P.O. Box 27244  
Chinatown Station  
Honolulu, HI 96827  
Hdq. Hotel: None selected  
Agent: Not appointed

Jan. 8-12, 1980 Ultrasound Conference, co-sponsored by the Honolulu Medical Group, Research and Education Foundation, 20 Category I credit hours.

Jan. 12-18, 1980 15th International Surgical Congress (Ten Surgical Specialties) Sheraton Waikiki, 20 Category I credit hours, Pan Pacific Surgical Association.

Jan. 14-20, 1980 Estes Park Institute

Jan. 19-21, 1980 Common Obstetric and Gynecological Problems, co-sponsored by Tulane University School of Medicine, Department of Ob-Gyn, and Hawaii Section of ACOG, 15 Category I credit hours, 15 cognates ACOG.

Feb. 1-4, 1980 Hawaii Review, co-sponsored by the Hawaii Chapter of AAFP, with invitation to BC Chapter College of Family Physicians of Canada, and Section of General Practice, BC Medical Association.

Mar. 1-8, 1980 American Urological Association, Western Section, King Kamehameha Hotel and the Sheraton Waikiki.

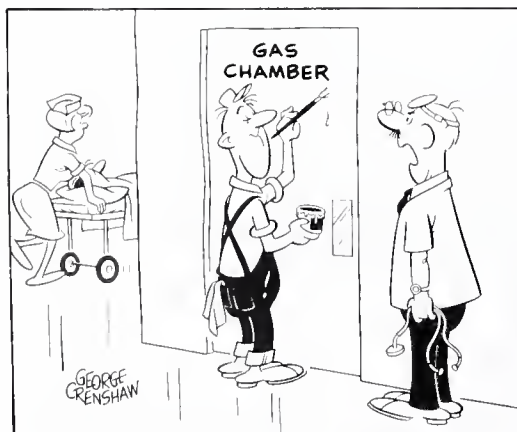
Mar. 18-22, 1980 Sports Medicine, Department of Physiology, Princess Kaiulani, 18 Category I credit hours.

Mar. 31-Apr. 4, 1980 Current Concepts in Obstetrics and Gynecology, co-sponsored by the University of Washington, Dept. of Ob-Gyn and Hawaii Section of ACOG, Ilikai Hotel, 24 Category I credit hours, 24 cognates ACOG.

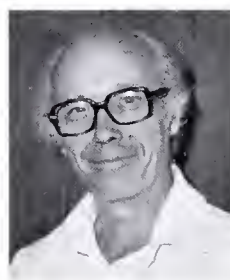
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## OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



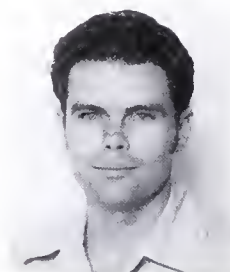
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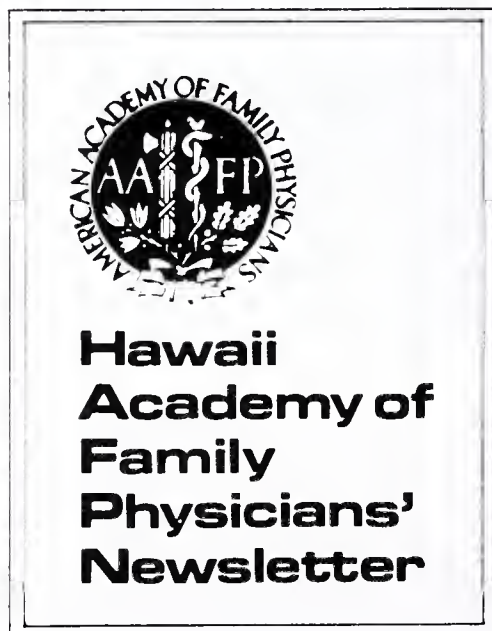
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**Vincent P. McCarthy, M.D.**

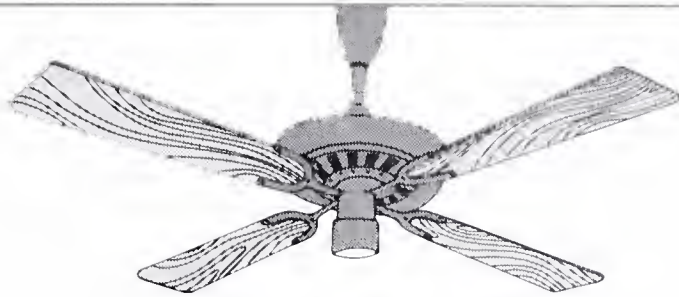
98-1247 Kaahumanu Avenue  
Aiea, Hawaii 96701

PEDIATRICS



**New Members**—Oscar Sablan, UHSM and spouse of Resident Affiliate member **Marcia Sablan MD** is a new Student member in his last year at the local medical school. **Douglas D. Foster MD** is a new Active member and ABFP by transfer in; he is locating at Ewa Beach. Welcome to both!





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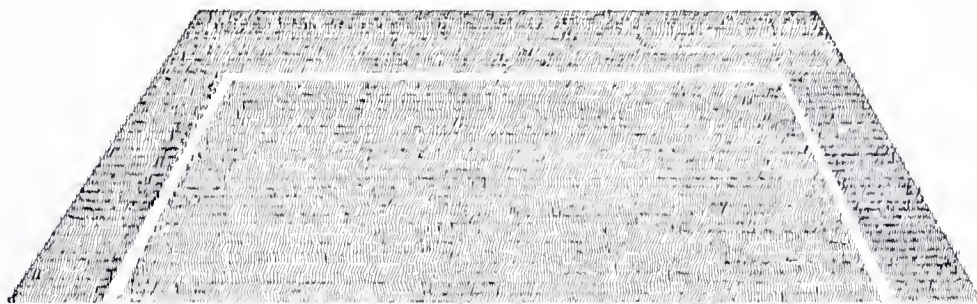
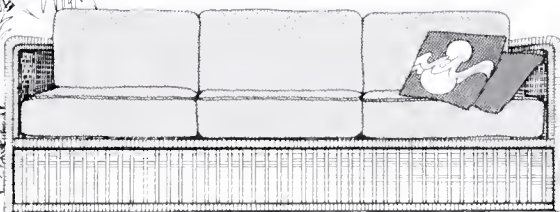
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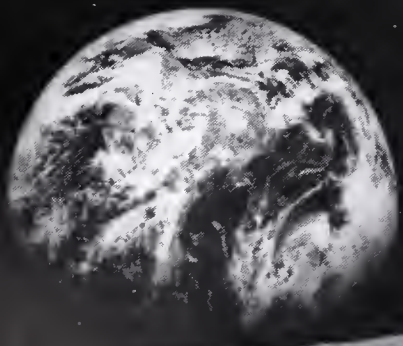
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**Dropped from our Rolls—Bruce Hong MD**, by transfer to the Iowa Chapter.

**News of Members—Don Newman**, who is with the Molokai Clinic, came out big as life in a photograph in the Molokai Free Press, a semi-monthly published on the Friendly Isle by Sam Peters, on 20 June. He was "caught on his day off sporting a T-shirt labeled 'Faith Healer.'" His beard (red), his laugh and his papale in that order fitted his role. **Marc Shlachter**, on the contrary, appeared woebegone and sheepish with his arm in a sling in the hallway at Castle Hospital; he had come off second best in a collision with a dog while riding his moped, suffering an A-C separation.

**UHSM Faculty**—includes the following members of HAFP (courtesy of **Ron Hattis**): Assoc. Prof. **Mona Bomgaars**; Clinical Assoc. Prof. **Ron Hattis**, **Milton Howell** and **Fred Reppun**; Ass't Prof. **Don Farrell**; Clinical Ass't Prof. **Ernest Bade**, **Noberto Baysa**, **Tom Cahill**, **Fred Dodge**, **Cliff Druecker**, **Fred Lam**, **Harold Machigashira**, **Rod Miller**, **Jim Mitchell**, **Helen Percy**, **Varian Sloan**, **Richard Tesoro**, **Bob Todd**, **Jim Tsuji**, **Pat Walsh**, **Mark Wentworth**, **Arch Wigle**; Clinical Instructors **Richard Lee-Ching**, **Jin Tokeshi**, **Nathan Wong**; Clinical Teaching Ass'ts **Bob Major** and **Dale Wicklund**.

**Hawaii Review 1-4 Feb 80**—word has been received that some 150 Canadian FP members have signed up for the joint HAFP/British Columbia Chapter, College of Family Physicians of Canada week-long seminar at the Hilton Hawaiian Village; so far, there are only 4 from Hawaii who have paid their entrance fee of \$150. After 15 December 78, the fee will go up to \$165. The Council, HAFP, voted at its 19 July meeting to invite AAFP student members to attend for free; medical students who are not members will be charged a fee of \$10 to register. By now, most physicians in Hawaii should have received a brochure in the mails.

**C.M.E.**—A reminder to sign up for Core Content Review; registration deadline is 31 August for the 1979-1980 eight month, 32 hour "P" credit, \$60 correspondence course. The Georgia AFP is offering "Primary Care Update" in seven segments at 8 hours of "P" credit each; registration deadline is 3 December and the course starts on 7 Jan 80; the fee varies from \$295 to \$475, depending on what is taken.

**Next Dinner Meeting**—will be at **Jasinski's** on 15 September 1979.

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# EARN UP TO 25 HOURS OF CATEGORY 1 CREDIT

**AMA Regional Continuing Medical Education Program**  
**Monday through Friday October 8-12, 1979**  
**Ilikai Hotel**  
**Honolulu, Hawaii**



**In cooperation with**  
**Hawaii Medical Association**  
**and in conjunction with**  
**Hawaii Medical Association**  
**Annual Convention**

That's right, you can wrap up a half-year's CME requirements toward the AMA Physician's Recognition Award at this one meeting. Choose from 24 five-hour Category 1 postgraduate courses in such specialty areas as cardiology, internal medicine, obstetrics-gynecology, family practice, pediatrics, and general surgery. In addition, there will be a new Video Clinic featured each day, with a 100-page syllabus included with each Clinic.

*This Regional Continuing Medical Education Program is presented by the AMA Council on Continuing Physician Education in cooperation with the Hawaii Medical Association. As an organization accredited for continuing medical education, the AMA Council on Continuing Physician Education certifies that the continuing medical education activities designated Category 1 meet the criteria for Category 1 on an hour-for-hour basis for the Physician's Recognition Award of the American Medical Association.*

**Note: M—AMA Member; N—Nonmember**

**00P1 Basic Electrocardiography—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Principles underlying the genesis of the electrocardiogram will be given. The normal electrocardiogram will be reviewed in the context of the basic principles. The role of computers in electrocardiography will be discussed. At the end of the course, participants should be able to recognize the following: atrial and ventricular hypertrophy, myocardial infarction, pre-excitation syndrome and bundle branch block. The course is designed for persons with a limited background in electrocardiography. **Course Director:** Michael Bilitch, MD—Los Angeles.

**00P2 Office Dermatology—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will present practical pointers and other pearls to aid the practitioner in his management of skin problems. California and Hawaiian clinicians and teachers will share their thoughts and experiences with you. Dermatology from Acne to Zoster will be covered with emphasis on skin cancer (diagnosis, prevention and treatment), contact dermatitis and other allergies, psoriasis, herpes simplex, neurodermatitis and fungal infections. The wiki-wiki (hurry-hurry) rounds will present rapid fire answers to your diagnostic and therapeutic questions. **Course Director:** Norman Goldstein, MD—Honolulu.

**00P3 Pulmonary Disease Update—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • This course will be directed to the practicing physician. Topics to be presented include interstitial pneumonitis and pulmonary fibrosis, current therapy of asthma, sleep apnea syndrome, and the use of the ventilator in respiratory failure. In addition to didactic presentations, there will be a one-hour panel discussion of illustrative case material. The program will be kept sufficiently informal to allow free dialog and questions to the

## Unwind with hours of R & R

All classes end at 1 p.m. so the rest of your days are free to enjoy the unique attractions of Hawaii. Surfing, sightseeing, deep sea fishing, snorkeling, outrigger canoe riding—the choice is yours. Or, you might prefer to just lie back on the golden sand and let the warm Hawaiian sun and gentle Tradewinds work their wonders. And by all means plan to attend the many enjoyable social activities planned in conjunction with the meeting.

## Special Activities:

The Hawaii Medical Association will hold an opening Welcome and Cocktail Reception in the Pacific Ballroom of the Ilikai Hotel on Monday, October 8 from 5 to 7 p.m. Golf enthusiasts may sign up for the HMA Golf Tournament scheduled for Thursday, October 11. Thursday evening you may wish to join in the Sportsmen's Night Dinner at the Japanese Kanraku Tea House. The Hawaii Medical Association Annual Banquet will be held Friday evening, October 12, at the Ilikai Hotel, in the Pacific Ballroom. Details on these special activities and reservations may be obtained from the Registration Desk at the Ilikai Hotel, or by direct correspondence with the Hawaii Medical Association, 320 Ward Avenue, Honolulu, Hawaii 96814.

faculty. **Faculty:** Bruce A. Soll, MD, Course Director—Honolulu; Richard Winterbauer, MD—Seattle; and Clifford Zwillich, MD—Denver.

**00P4 Psychotropic Drugs: Present Uses, Present Problems—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Four major topical areas will be covered: antipsychotic drugs; antidepressants; antianxiety agents; and lithium. Emphasis on each area will be to enhance the practitioner's understanding of the pharmacologic principles underlying the proper clinical use of psychotropic drugs. Each faculty member will present views regarding the use of each of these drugs, affording a greater spectrum of opinion. A considerable amount of time has been scheduled for discussion and questions involving the faculty and audience. The goal will be to assist the primary care physician as well as the specialist in using these drugs effectively and safely. **Faculty:** Leo Hollister, MD, Course Director—Palo Alto, Calif.; and Joe Tupin, MD—Davis, Calif.

**00P5 Management of Hypertension—Mon., Oct. 8—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Correct concepts in the diagnosis, pathophysiology, and therapy of hypertension will be reviewed with special emphasis on recent developments of significance and applicability to the physician in practice. Use of beta-adrenergic blockade and angiotension conversion inhibition will be discussed. **Course Director:** Dennis R. Meyer, MD—Honolulu.

**00P6 Backache (Video Clinic)—Mon., Oct. 8—8:00 AM-12:00 Noon (4 hours: M-\$30; N-\$40)** • Objective of this videotape course is to review etiology and to teach the newest concepts in diagnosis and management of major entities causing low back pain, including demonstration of diagnostic and management techniques. At the conclusion of the Clinic, the physician should be able to perform an accurate differential diagnosis; determine which cases require specialty consultation; and administer appropriate nonsurgical treatment. **Course Director:** Edgar C. Dawson, MD, Division of Orthopaedic Surgery, School of Medicine, University of California—Los Angeles.

**00P7 Cardiac Arrhythmias—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • The anatomic and electrophysiologic basis of cardiac arrhythmias will be reviewed. Normal impulse formation and conduction will be described. Diagnostic modalities including the electrocardiogram, Holter monitoring, stress testing and intracardiac stimu-



lation (His Bundle studies) will be discussed. At the end of the course, participants should be able to recognize the following: atrial arrhythmias (flutter, fibrillation, tachycardia), ventricular arrhythmias (extrasystole, tachycardia, fibrillation), sino-atrial disease (sinus arrest and sick sinus syndrome) and atrioventricular block. The course is designed for persons with a limited background in arrhythmias; they should have a working knowledge of the electrocardiogram. **Course Director:** Michael Bilitch, MD—Los Angeles.

**00P8 Office Gynecology—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Directed to the primary care physician, with some discussion of office records and notes, program will discuss common problems seen in the office. Topics will include dysfunctional and menopausal bleeding; colposcopy and cryosurgery; contraceptives and ambulatory office surgery and office sterilization. Lectures will also discuss urethral lesions, vulvitis and vaginitis, routine examination of the breasts, and thoughts on second opinions and unnecessary hysterectomies. Time allowed for question and answer session. **Faculty:** Joseph H. Pratt, MD, Course Director—Rochester, MN; Purvis Martin, MD—San Diego, CA; and William Russell, MD—Phoenix, AZ.

**00P9 Rational Use of Antimicrobials—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will address sensitivity testing techniques, factors that influence patients' responses to antibiotics, and the newer cephalosporins, aminoglycosides, and penicillins. Using this information, physicians will be better able to select an antibiotic for use in serious infections such as pneumonia, bacteremia, endocarditis, and meningitis. Lectures, discussion groups, and case histories will be used. **Faculty:** To be announced.

**0P10 Thyroid Disease—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Applications of thyroid function tests to diagnosis of thyroid disease are emphasized. Case presentations illustrating diagnosis, management, and care of patients with hyperthyroidism, hypothyroidism, thyroid nodules, and thyroiditis will include suitable periods for open discussion, questions, and answers. **Course Director:** Ralph M. Beddow, MD—Honolulu.

**0P11 Fluid and Electrolyte Balance—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will be divided into basic physiology of fluid and electrolyte imbalance as well as acid base balance with in-depth discussion of cases illustrating abnormal physiology. Sodium and potassium metabolism as well as metabolic acidosis and metabolic alkalosis with respiratory compensation will be the topic of discussion. Emphasis will be on a practical approach to the management of these difficult problems in clinical medicine. In addition to demonstrating methods of accurate diagnoses of fluid and electrolyte and acid base problems, appropriate management will be discussed. **Faculty:** Dudley S. J. Seto, MD, Course Director; Robert S. Morrison, MD; and David C. Yuan, MD—Honolulu.

**0P12 Practical Rheumatology (Video Clinic)—Tues., Oct. 9—8:00 AM-1:00 PM (5 hours: M-\$35; N-\$47.50)** • Course will review diagnostic techniques and teach the newest concepts in the management of rheumatic diseases. Upon completion of the Clinic, the physician should be able to perform an accurate differential diagnosis; identify and treat ten manifestations of soft tissue rheumatism; describe the typical distribution pattern of rheumatoid arthritis and the problems associated with its management; and be familiar with all treatment of chronic rheumatic diseases. **Course**

**Director:** Rodney Bluestone, MD, MRCP, Dept. of Medicine, School of Medicine, Univ. of California—Los Angeles.

**0P13 Common Neurological Problems and Their Treatment—Wed., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course is oriented toward the practical aspects of neurological diagnosis and therapy that can make a difference in your patients. Special attention will focus on the neurological screening history and examination, and the major clinical categories of neurological disease: headache, stroke, coma, and other treatable neurological diseases. **Faculty:** James Austin, MD, Course Director; Stuart Schneck, MD; and Philip Yarnell, MD—Denver.

**0P14 Chronic Pain Management—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course will deal with the causes, diagnosis, and management of chronic pain conditions. The role of various treatment modalities for chronic pain will be critically discussed. These will include the place of medications in pain control, and also the management of medication abuse in the chronic pain patient, behavioral strategies for dealing with chronic pain, and a critical discussion of some of the more innovative treatments for pain, such as transcutaneous stimulation, acupuncture, biofeedback, etc. **Faculty:** Terence M. Murphy, MD, Course Director; Edmond Charlton, MD; and Wilbert Fordyce, PhD—Seattle.

**0P15 Diagnostic Imaging of the Chest & Abdomen—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • Course is oriented to the relationships between ultrasound, nuclear medicine, and computed tomography in diagnosis of conditions of the chest and abdomen. Comparison of the various modalities will be made, stressing understanding of protocols related to diagnostic problems. Program is aimed at the general practitioner, internist, and surgeon rather than the expert in diagnostic imaging. Often, the attending physician is confused with the multiplicity of imaging modalities available, and we will attempt to demonstrate a logical approach to common diagnostic problems using these three imaging methods. **Faculty:** Richard D. Moore, MD, Course Director—Honolulu; and L. Rosenthal, MD—Montreal.

**0P17 Diagnostic Procedures for the Acute Cardiac Patient—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85)** • The course will deal with the limits and capabilities of the new diagnostic procedures for cardiac disease. Included will be discussion of cardiac x-rays, use of scanning after injection of gallium 67 and technetium 99m, testing with the treadmill, echocardiography, and other ancillary methods of identifying heart pathology. The course will deal with the most prevalent types of disease, their recognition and guides to appropriate therapy. **Faculty:** Danelo Canete, MD, Course Director; Vincent Friedwald, MD; Eugene Magnier, MD; and Maurice Reeder, MD—Honolulu.

**0P18 Vulvovaginal Problems (Video Clinic)—Wed., Oct. 10—8:00 AM-1:00 PM (5 hours: M-\$35; N-\$47.50)** • Objective of this videotape program is to review the problems of the vulva and vagina and to teach the newest concepts in differential diagnosis and management of nonvenereal and venereal infections seen in office practice, stressing recognition of masquerading or underlying neoplasia. **Course Director:** Thomas B. Leberherz, MD, Department of Obstetrics and Gynecology, School of Medicine, University of California—Los Angeles.



**0P19 Mass Media Seminar—Tues., Oct. 9—8:00 AM-4:00 PM & Wed., Oct. 10—9:00 AM-12:00 Noon (11-hour, 2-day course: M-\$130; N-\$195) •** This course is designed for official spokespeople who represent their medical organization in print and broadcast interview situations and who officially commit their organization to the news record. Interview situations are videotaped and evaluated by expert faculty. This is a one and-a-half day seminar. **Course Director:** Mort Enright, MAT, AMA-Chicago. (NOTE: This course conveys Category 2 credit.)

**0P20 Perspectives in Immunology 1979—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** Course will provide a current updating in selected topics in basic and applied clinical immunology. Recent knowledge of the cellular and molecular events of the primary and secondary immune response will be discussed. New information regarding the pathogenesis of autoimmune diseases such as lupus erythematosus and rheumatoid arthritis will be presented in terms of differential primary diagnosis and evaluation of disease activity. On completing the course, the practitioner will be able to explain basic mechanisms of immune responsiveness, the pathogenesis of immunologic injury, and select the laboratory tests appropriate to the differential diagnosis of immunologic diseases. **Course Director:** Ernest S. Tucker, III, MD—La Jolla, Calif.

**0P21 The Acute Surgical Abdomen—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** Inflammatory lesions, including perforations; intestinal obstruction; vascular catastrophies and abdominal trauma may produce "the acute surgical abdomen." Delays in diagnosis and management may be disastrous as the patient's condition may deteriorate rapidly without timely and appropriate management. The objectives of this workshop are aimed at primary care physicians to whom the initial evaluation of such patients falls. **Faculty:** Thomas J. Whelan, Jr., MD, Course Director; J. Judson McNamara, MD—Honolulu; Leonard Rosoff, MD—Los Angeles; and James Carrico, MD—Seattle.

**0P22 Anemias Update 1979—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** Course will review and discuss the new techniques for diagnosing the various etiologies of anemia. Topics will include the hemolytic anemias, refractory anemias, and megaloblastic anemias. Time allowed for panel discussion and question-and-answer session with the faculty. **Course Director:** Christian L. Gulbrandsen, MD—Honolulu.

**0P23 Office Gynecology—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** Repeat of Course 00P8.

**0P24 Office Dermatology—Thurs., Oct. 11—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** Repeat of Course 00P2.

**0P25 The Comatose Patient (Video Clinic)—Thurs., Oct. 11—8:00 AM-11:00 AM (3 hours: M-\$25; N-\$32.50) •** This videotape course, directed to the primary care physician, will present a procedure-oriented approach to the comatose patient. It demonstrates the evaluation, initial therapy, differential diagnosis, physical examination and laboratory studies as applied to several causes of unconsciousness including drug overdose, concussion, diabetes, intracerebral hemorrhage, stroke, Stokes-Adams attack, psychiatric causes, and alcohol withdrawal. **Course Direc-**

**tor:** Marie Silver, MD, Department of Emergency Medicine, School of Medicine, University of California—Los Angeles.

**0P26 Practice Management—Managing the Business Side—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** Course is designed to help improve your appointment scheduling, increase collections, aid in facility design, develop effective personnel policies, and reduce paperwork. You will learn time-saving medical management techniques. Lectures, visuals, and discussion—with time for questions and answers—are combined to increase management skills and efficiency. Designed for established physicians in solo practice or group practice, the course has also proved beneficial to young physicians entering practice. **Course Director:** Jack Walsdorf—AMA-Chicago.

**0P27 New Horizons in Pediatrics—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** This workshop is designed to provide the practicing pediatrician or primary care physician with an in-depth view of new developments in diagnosis, assessment, and management of pediatric patients with particular emphasis on hematology, infectious diseases, allergies, and newborn medicine. Time allowed for question-and-answer session with faculty members. **Faculty:** Raul Rudoy, MD, Course Director; Rodney Boychuck, MD; Stuart Rusnak, MD—Honolulu; and Irving Shulman, MD—Stanford, CA.

**0P28 The Eye and You—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** This course is designed to update the non-ophthalmologist in the latest developments in ophthalmology. Special emphasis will also be placed on giving the primary care physician advice on when to refer a patient and what results can be expected from treatment. Specific topics to be covered will include: glaucoma, intraocular lenses, amblyopia and strabismus, vitreous and laser treatment, indications and results. **Faculty:** Malcolm R. Ing, MD, Course Director—Honolulu; Blaine S. Boyden, MD—San Francisco; and Robert E. Christensen, MD—Los Angeles.

**0P29 Common Gastrointestinal Disorders—Fri., Oct. 12—8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** This clinically-oriented course is designed to provide current information on the most common problems encountered in the gastrointestinal tract. Areas to be covered will include esophagitis, peptic ulcer disease, inflammatory bowel disease, gallstones, pancreatitis, and hepatitis, and chronic liver disease. **Faculty:** Gary A. Globet, MD, Course Director; Harold Conn, MD; and Jon Isenberg, MD—Honolulu.

**0P30 Diabetes: Practical Aspects — Fri., Oct. 12 — 8:00 AM-1:00 PM (5 hours: M-\$60; N-\$85) •** This course is designed to provide the practicing physician with an update regarding the diagnosis and treatment of diabetes mellitus. It will emphasize office practice and will include the importance of patient education, diet therapy as well as the prevention and management of diabetic complications. The principles of insulin therapy will be emphasized both in the outpatient management of diabetes mellitus and for its acute metabolic complications. An informal question and answer session will follow the formal presentations. **Course Director:** Max Botticelli, MD—Honolulu.

**0P31 Neurological Examination (Video Clinic)—Fri., Oct. 12—8:00 AM-3:00 PM (6 hours: M-\$40; N-\$55) •** This videotape course will review the neurological examina-

tion and demonstrate procedures at the patient's bedside as part of the general assessment of the patient. The course will teach techniques, discuss the purpose of each part of the examination and show patients with relevant problems. **Course Director:** Howard Barrows, MD, Department of Neurology, McMaster University, Health Sciences Centre, Hamilton, Ontario.

**SPECIAL NOTE:** The foregoing information is at variance with our "AMA Continuing Medical Education Catalog." **This** information is the latest, corrected line-up of Honolulu CME course numbers, titles, dates, hours, credits, and prices.

HOTEL RESERVATION REQUEST

AMA Regional Meeting  
Ilikai Hotel/Honolulu, Hawaii  
October 8-12, 1979

**Note:** September 30, 1979 is the last date that rooms are being held for this meeting. After this cut-off date, reservations will be accepted only if rooms are available. A one night's room deposit is required with this form. Please make check payable to the Ilikai Hotel.  
Please Print

Name(s) \_\_\_\_\_  
Office Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Office Telephone No. (\_\_\_\_\_) \_\_\_\_\_  
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Total number in party \_\_\_\_\_

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(Daily, plus 4% Hawaii State Tax) Twin \$52  
Triple \$62  
Deluxe Tower Ocean View Single \$59  
(Daily, plus 4% Hawaii State Tax) Twin \$62  
Triple \$72

Deposit of \$ \_\_\_\_\_ is enclosed  
Arrival Date \_\_\_\_\_ Time \_\_\_\_\_  
Departure Date \_\_\_\_\_ Time \_\_\_\_\_

Return this form with deposit by September 30 to: **Room Reservations Department  
The Ilikai Hotel  
1777 Ala Moana Boulevard  
Honolulu, Hawaii 96815**

**REGISTER EARLY!**  
Use the coupon shown to make your course selections. We'll confirm your enrollment immediately. Your tickets and course registration materials will be sent to you on Sept. 12, 1979. Requests for course tickets received after this date will be held for you at the AMA-CME Registration Desk at the Ilikai Hotel. If the minimum course registration for your first choice is not attained, or if the course is fully subscribed, one of your alternate choices will be substituted. Course sizes are limited—register early. Please make your hotel reservations on the form provided for that purpose. **NOTE:** Breakfast and coffee breaks will be provided for all meeting participants each day.

**Honolulu Course Registration**  
Please return to: **AMA Department of Meeting Services  
535 North Dearborn Street  
Chicago, Illinois 60610  
Phone inquiries: (312) 751-6503**

**Please note:** The course registration fee for nonmember physicians is approximately 50% higher than the fee for AMA members. Medical student members of the AMA and student nonmembers will be admitted to courses at no fee on a space available basis one hour prior to course sessions; however, nonmember medical students must pay a \$15.00 gate fee. A 50% discount on course fees is given to retired physicians and physicians in postgraduate years 1 through 6 based on current status as physician member or nonmember. **Payment must accompany choice of course(s) requested on this registration coupon.**

Please Print or Type  
Physician M.E. No. \_\_\_\_\_  
Name: \_\_\_\_\_  
Office Address \_\_\_\_\_  
City/State/Zip Code \_\_\_\_\_  
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Membership 1 ☐ AMA Member 2 ☐ Nonmember  
Status 1 ☐ Physician 2 ☐ Resident 3 ☐ Student  
4 ☐ Allied Health 5 ☐ Other

Date	Course No 1st Choice	Fee	Course No 2nd Choice	Office Use Only Ticket No
Monday October 8, 1979	_____	_____	_____	_____
Tuesday, October 9, 1979	_____	_____	_____	_____
Wednesday, October 10, 1979	_____	_____	_____	_____
Thursday, October 11, 1979	_____	_____	_____	_____
Friday, October 12, 1979	_____	_____	_____	_____

HAWAII MEDICAL ASSOCIATION CONVENTION  
REGISTRATION FEE\* \$25.00  
TOTAL COURSE FEE REMITTANCE \$ \_\_\_\_\_  
GRAND TOTAL \$ \_\_\_\_\_

NOTE: All courses are five-hour, one-day courses with the exception of Course OP19, which is an 11-hour, two-day course.  
\*A \$25.00 convention registration fee is required of all physicians not members of the Hawaii Medical Association.

**HMA House of Delegates Annual Meeting**  
Monday, October 8, 1979, 1:30 PM  
Opening Session: Reference Committee Hearings  
Guest: Hoyt D. Gardner, M.D., AMA President  
Wednesday, October 10, 1979, 1:30 PM  
Final Session

**Hawaii Thoracic Society Annual Meeting,**  
**Monday, October 8, 1979, 7:00 PM and**  
**Fireside Chat Conference, Cat. I, 2 hours,**  
**7:30 PM**  
Contact: R. Respicio, 537-5966

**Special Seminar on Skin Cancer, Monday,**  
**October 8, 1979, 7:30 PM**  
**Special Medical Collection Management Course**  
This course for Medical Assistants will be conducted on Tuesday, October 9, 1979, 1:00 PM by AMA practice management staff.  
The same course will be presented on Wednesday afternoon, October 10 at the Maui Palms Hotel in Kahului for Maui County medical assistants. Send \$25 course registration fee in advance to Bureau of Medical Economics, 111 North King Street, Suite 309, Honolulu 96817; attention Harold Yamaguchi.



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To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk

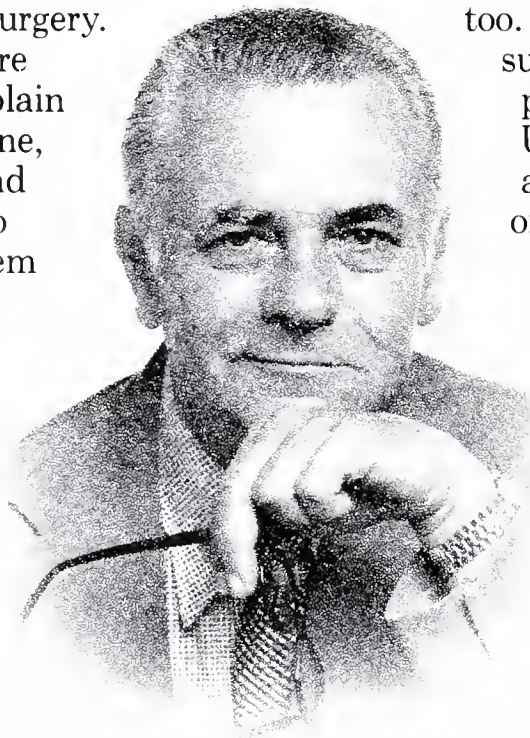
about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know.

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# Old Fashioned Dialogue is Back.

**HMSA Utilization Review Department**

**Ph: 944-2355**





SEPTEMBER, 1979  
VOL. 38, NO. 9

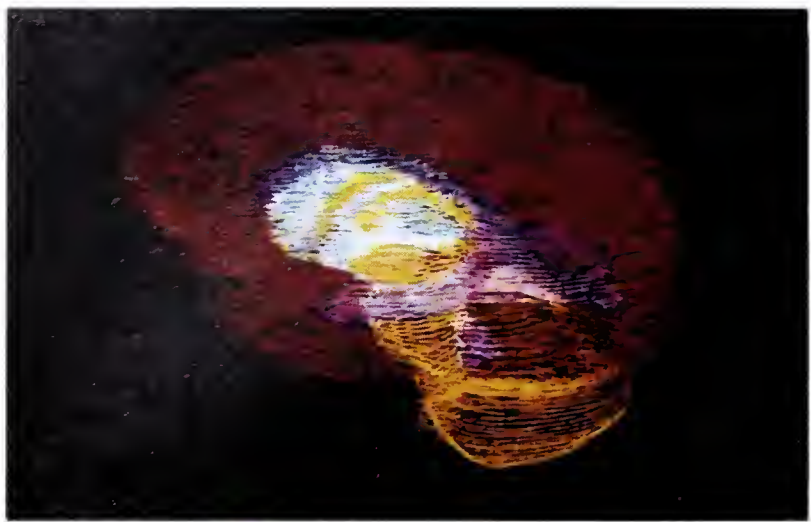
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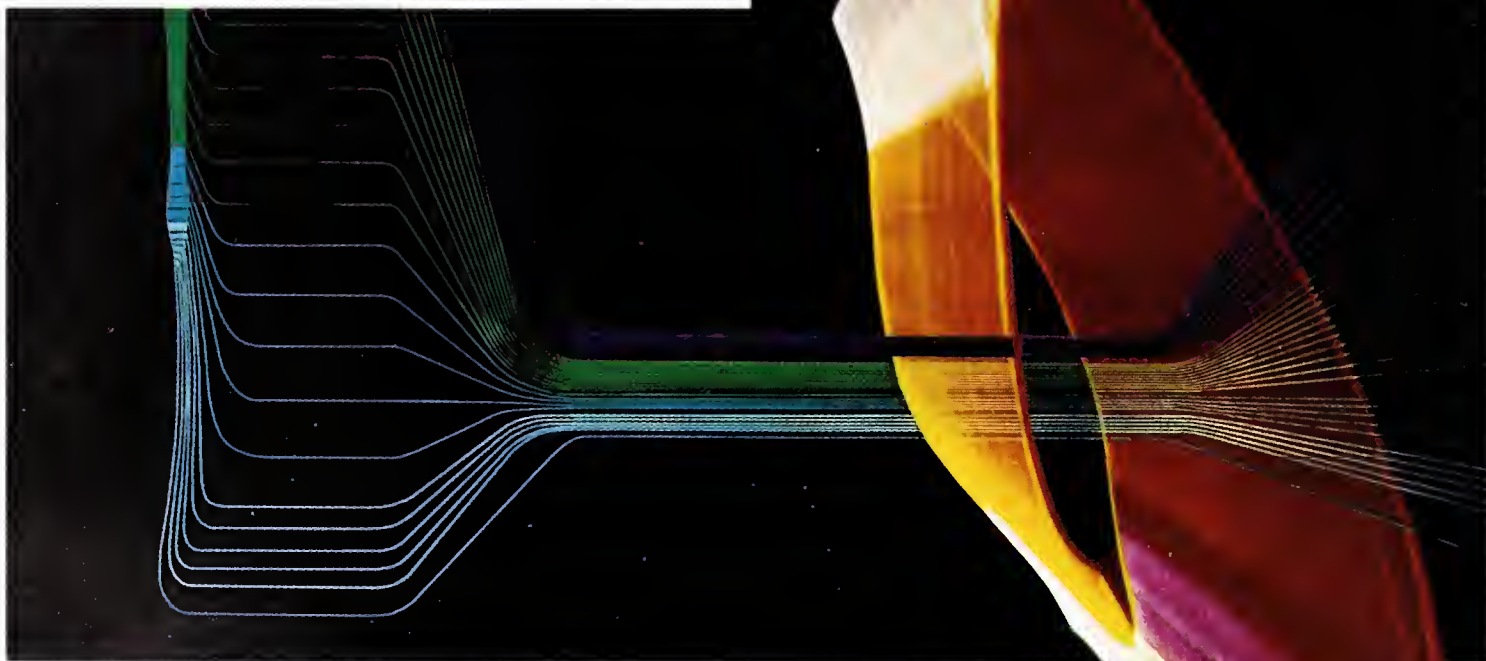
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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants

may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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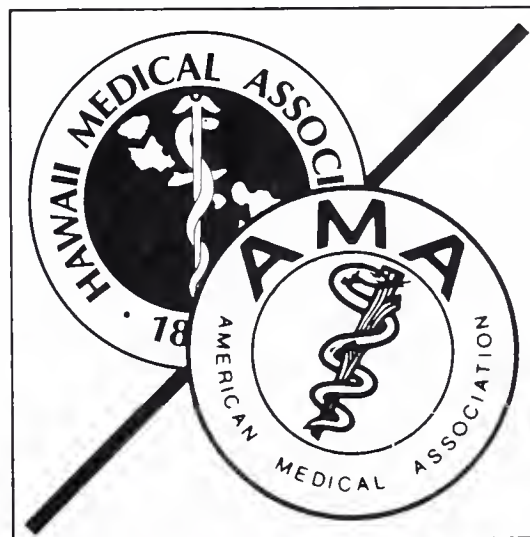
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# The Maker

## Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



*MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.*

**FACT: The Food and Drug Administration** does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

*MYTH: Industry favors only "expensive" brand names and denigrates all generics.*

**FACT: PMA companies** make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



# Matters.

**MYTH:** Generic options always exist.

**FACT:** About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for every 45 percent of such expenditure, is a generic prescribing option available.

**MYTH:** Generic prescriptions are filled with expensive generics, thus saving consumers large sums of money.

**FACT:** Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from the same well-known and trusted sources, in the best interests of patients. In most cases the patient receives the same proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

**MYTH:** Drugs account for a major portion of the rise in health care costs.

**FACT:** Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

**MYTH:** Government intrusions into the marketplace will save tax money.

**FACT:** Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

## The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

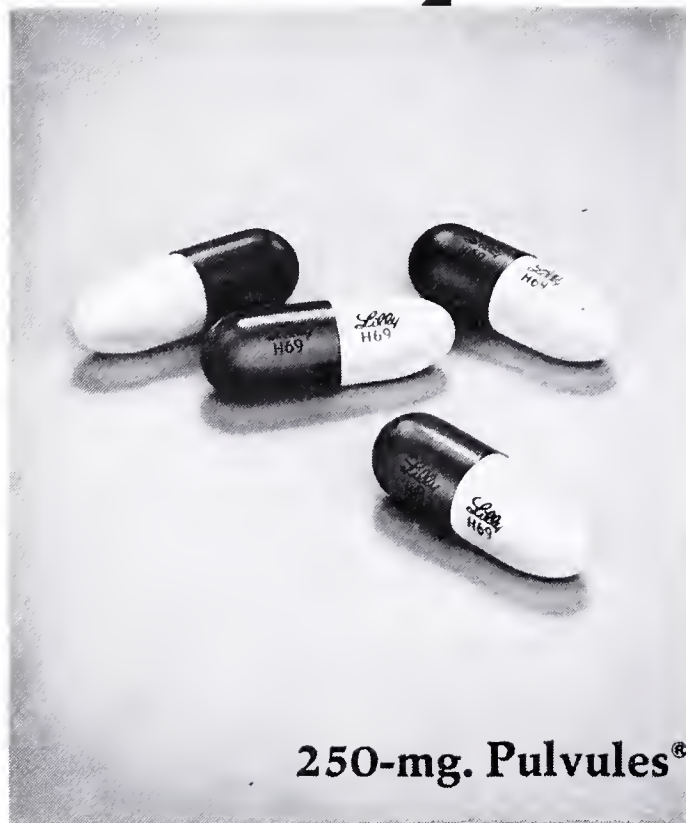
## The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



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# Human Hawaiian Marine Sponge Poisoning

J. K. SIMS, M.D.\* and MICHAEL Y. IREI, A.B., Honolulu

*In June 1977, a caucasian woman was stung on the hands by a red-orange marine sponge collected at Waimanalo, Oahu. Contact dermatitis developed, with erythema, itching, tenderness, burning, and stinging. Dilute vinegar soaks (5% acetic acid) ameliorated the condition significantly. The sponge incriminated was subsequently tentatively identified as the Hawaiian fire sponge, *Tedania ignis* (Duchassaing & Michelotti, 1864).*

Of over 4000 species of sponges worldwide,<sup>1</sup> at least 63 occur in Hawaiian waters,<sup>2-4</sup> including 24 shallow-water species presently known to occur only in the waters of the Hawaiian Islands.<sup>2</sup> Our cross-referencing of Dr. Bruce Halstead's 13 toxic sponge species<sup>1,5,6</sup> with the Hawaiian sponge species listings of Berquist<sup>2</sup> and DeLaubenfels<sup>3,4</sup> revealed one certain example of a toxic Hawaiian marine sponge, *Tedania ignis* (nomenclature difficulties acknowledged<sup>3</sup>), and 4 to 5 other possible toxic marine sponges, depending on species (*e.g.* certain *Callyspongia sp.*, *Microciona sp.*, *Dysidea sp.*, *Tedania sp.*—*Tedania macrodactyla* or *Tedania toxicalis*?). DeLaubenfels indicated in 1950 that *Tedania ignis* "is very common throughout the shallow waters of Hawaii including Kaneohe Bay."<sup>3</sup> Therefore, the Hawaiian fire sponge *Tedania ignis* was a prime suspect when a skin diver reported being stung on both hands by some red-orange sponge inadvertently collected on Oahu.

## Case Report:

The patient was a 72-year-old woman who regularly snorkels in Oahu's shallow waters to collect shells and corals for preparing shell mosaic gifts. On 6/21/77 she collected some calcified calcareous algae (*Porolithon sp.*) resembling coral, in Pacific Hawaiian waters 1-2 meters deep, immediately offshore Kaiona Beach Park, Waimanalo, Oahu, Hawaii. Upon washing the pieces of calcified algae in hypotonic fresh water at home, she developed redness, itching, tenderness, burning, and stinging of multiple areas on both hands (left worse than right). She described the situation like putting her "hands into a bee's nest." She examined the calcified algae more carefully and noted some "sponge . . . a reddish sponge."

Local application of Bactine<sup>TM</sup> and aloe lotions were not felt by her to be helpful. Local 0.5% flurandrenolide cream (Cordram) and 25mg oral diphenhydramine (Benadryl) on 6/23/77 did not alleviate the symptoms, and bilateral purpuric mottling of the hands developed.

She contacted one of us (JKS) on 6/24/77, and was instructed to thoroughly rinse all affected areas of the hands several times with isopropyl alcohol, followed by soap-and-water washes. The alcohol washes provided significant symptomatic relief. The morning of 6/25/77, this lady was placed on dilute vinegar (5% acetic acid) soaks 3 or 4 times a day. At this time, multiple 1-2 mm-diameter vesicles on both hands were noted, the vesicles being slightly yellowish with clear fluid inside. The vinegar soaks provided significant further relief of the symptoms, and reduced the itching, according to the patient. No skin biopsy was taken. Her hands peeled during the week of 7/10/77-7/17/77, and all other symptoms had disappeared by then. Followup on 8/30/78 revealed that she had remained symptom-free since 8/77.

From the Hawaii Medical Association's Emergency Medical Services Program (HMA-EMSP), 1301 Punchbowl Street, Honolulu, Hawaii 96813.

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Accepted for publication April, 1979.

### Materials and Methods

The patient brought a specimen of the Kaiona Beach Park toxic sponge to one of us (JKS) on 6/27/77. The sponge was reddish-orange, adhered tightly to the calcified alga substrate, was friable, and had the "crumb of bread"<sup>3</sup> (Figures 1-2) appearance consistent with *Tedania ignis*. Even the dry sponge specimen produced local itchiness upon contact with the unprotected

finger of one of us (JKS). Drying of the specimen over a one year period of time in room air produced a pasty light yellow-green white sponge from the fresh red-orange specimen.<sup>7</sup>

After the toxic sponge had dried for one year, 2-4 milliliters of the dry non-compressed sponge were carefully scraped from the calcified substrate into a clean glass container. Approximately 5 ml of concentrated nitric acid ( $\text{HNO}_3$

FIG. 1.—Photography by JKS showing the Left Palmar Lesions produced by the specimen of the red-orange sponge, *Tedania ignis*, being carefully held by the protected right hand.





FIG. 2.—Photograph showing the “crumb of bread” appearance of the toxic sponge, *Tedania ignis*.  
Photograph by Roy Cameron, Queen’s Medical Center, Honolulu.



—Mallinckrodt) were added to the sponge sample in order to break down the spongin architecture of the sponge and to release sponge spicules; 24-48 hours of nitric acid digestion of the sponge were allowed for spicule liberation. The nitric acid mixture was not “boiled off” as in the usual preparation of sponge spicules.<sup>2</sup> Nitric acid digestion of the sponge rendered a yellow solution, from which droplets were placed on a clean slide for light microscopy. The suspension of spicules and spongin in the concentrated nitric acid sponge digest was microscopically lucid and possessed spicules of a spectrum consistent with *Tedania ignis*.<sup>2-4</sup> The *Tedania ignis* spicules include the dermal tornote,<sup>3</sup> the endosomal megascleres style,<sup>2,3</sup> the microspined raphide,<sup>3</sup> the dermal megascleres tylote,<sup>2,3</sup> the microscleres onychaete,<sup>2</sup> and the strongyle,<sup>2</sup> all of specific dimensions and morphology. The color, gross morphology, and spicule array of this toxic Waimanalo sponge had led us to tentatively identify this sponge as *Tedania ignis* (and it should be compared with DeLaubenfel’s reference specimen labeled Moku O Loe location #6 deposit in the US National Museum, Register Number 22744<sup>3</sup>). Ovoid structures were seen

with the spicules (representing spores, candida-like yeast, or nematocysts?).

### Results and Discussion

A toxic marine sponge, herein tentatively identified as the fire sponge *Tedania ignis*, was inadvertently collected and stung the collector the same day when put in hypotonic fresh water. Interestingly, she was not stung while she collected the specimen underwater, but only when she handled the specimen with unprotected hands in hypotonic fresh water at home.

The differential diagnosis of marine stings is very lengthy, even in Hawaii; however, this woman’s unique history simplified the process of making a diagnosis. She became poisoned upon direct contact with a red-orange sponge attached to calcareous algae. Calcareous algae, such as *Porolithon* sp., are not presently known to produce contact human intoxication, so the differential diagnosis was reduced to:

- contact dermatitis from sponge poisoning or
- sponge fisherman’s disease

In human sponge poisoning,<sup>1,6-12</sup> or fire sponge poisoning, it has been repeatedly em-



phasized that "poisoning probably occurs through deposit of the toxin or toxins in the superficial abrasions produced by the fine, sharp spicules of the sponge."<sup>10-12</sup> In sponge fisherman's disease, sea anemones bearing nematocysts (e.g. anemones from the genus *Sagartia* or *Actinia*, specifically<sup>6,9</sup>) proliferate at the base of the sponge, and the sponge collector is stung by the nematocysts of the anemone growing about the sponge. Obviously, growth of a nematocystic anemone on a toxic marine sponge could cause sponge poisoning, or sponge fisherman's disease, or both disorders. In Hawaii, sea anemones from the nematocystic families Actiniidae and Sagartiidae are present,<sup>13</sup> so either *Tedania ignis* sponge poisoning or sponge fisherman's malady, or both could occur in Hawaii. It was not felt, however, that our patient's hand immersion in water produced aquagenic urticaria,<sup>14</sup> nor was the history positive for histamine-liberating medications.<sup>15-16</sup>

This patient was treated for both sponge poisoning and sponge fisherman's disease until the sponge could be carefully examined. She was first treated with isopropyl alcohol as the first step of the empirical management of nematocystic cnidarian envenomizations<sup>17</sup> (e.g. treatment for jellyfish, Portuguese Man O' War, stinging fire coral, stinging true coral, sea anemone stings). However her worsening of condition while on both a steroid and an H<sub>1</sub>-receptor blocking anti-histamine (i.e. —diphenhydramine) made the diagnosis of sponge fisherman's disease unlikely; the isopropyl alcohol possibly diluted out an alcohol-soluble component of the sponge poisoning toxin(s). The treatment of the sponge poisoning with dilute vinegar soaks produced the effective results which can be seen in sponge poisoning, except that the usual local skin desquamation took place within 3 weeks of the affliction instead of months afterward. Skin ulceration was not observed.

Microscopic examination of the sponge, after its digestion with nitric acid, demonstrated an abundance of spicules and permitted the tentative identification of the sponge as the toxic *Tedania ignis* . . . no stranger to Hawaiian waters.<sup>2-4</sup> The extraction of *Tedania ignis* toxins for identification has not been completed for this specimen. Provocative patch testing using *Tedania ignis* extracts was not done with our patient (a persistent dermatitis can result<sup>1,5,7,9</sup>); however, Yaffee and Stargardter demonstrated in 1963, for *Tedania ignis*, that repeated patch testing with up to a 50% saline suspension gave 50% of 12 human subjects a dermatitis lasting 3 to 5 weeks, and their dilute 1% suspension in one reactor produced an anaphylactoid reaction.<sup>7</sup>

#### Literature Review

Our patient was not the first to develop a *Tedania ignis* sponge poisoning dermatitis in Hawaii. The international sponge authority, M.W.

DeLaubenfels, in his 1950 report,<sup>3</sup> noted that: "*Tedania ignis* gives a pronounced irritation to most people who touch it (those with very calloused hands are safe). This irritation includes a reddening of the skin, swelling, extreme tenderness to the touch, and lasts 3 to 7 days. I obtained such an irritation from the Hawaiian *Tedania*, and this has influenced me in making my provisional identification."

It was also DeLaubenfels, in 1936,<sup>1,5</sup> who suggested using dilute solutions of acetic acid as an effective treatment for cutaneous sponge poisoning.

Human contact dermatitis from the various toxic sponges have been reviewed;<sup>1,5,7,9,18</sup> however, intoxications by the orogastric, nasogastric, pulmonary inhalational, and intravenous routes have not been reported in man. Human sponge poisoning, to date, has been an integumentary dermatitis, with some systemic aberrations being possible (e.g. anaphylactic or anaphylactoid phenomena<sup>7</sup>). Reports on eye damage by sponge poisoning were unavailable for our review, but such cases should be considered serious on the basis of experimental data.<sup>19</sup> Systemic involvement of man by sponge poisoning should always be considered serious, since there is no specific parenteral antidote for *Tedania ignis* toxin(s).

The little that is known about some of the various sponge toxins has been reviewed.<sup>1,5,6,9-12,18-24</sup> Very little is known about *Tedania ignis* toxin(s). The extensive lists<sup>10,11,12,24</sup> of substances isolated or identified from fresh water and marine sponges have not been adequately evaluated as possible sponge toxins, and some sponge toxins may actually be genus-specific or species-specific.

The geographic location of Hawaii is certainly consistent with the theory that sponge toxicity is inversely related to latitude,<sup>25</sup> although this needs to be prospectively confirmed for the Hawaiian *Tedania ignis*. All the toxins for the Hawaiian *Tedania ignis* sponge have not been identified, and known specific sponge toxins have to be identified in sponges species-by-species since the identification of a specific sponge toxin in one species of Porifera is not automatically extrapolatable to another genus or species of sponge. The Hawaiian *Tedania ignis* belongs to the class Demospongiae and has a skeleton of siliceous spicules and spongin fibers;<sup>2</sup> however the silica spicules from our sponge specimen were not observed to cause intoxication. This supports the concept of the chemical nature of the intoxication.<sup>1</sup> The chemical nature of the *Tedania* toxin (as opposed to the effects of the mechanical action of spicules) has also been observed in several pertinent animal studies which reflect the noteworthy toxicity of specific sponges to other living organisms. P.A. Zahl indicated to Dr. Bruce Halstead in 1953 that an aqueous extract of a caribbean *Tedania ignis* was



toxic to mice when injected intraperitoneally<sup>1</sup>. Also, in 1932, DeLaubenfels reported that a California *Tedania toxicalis* sponge killed crabs, fish, mollusks, and worms within one hour upon placing this species of sponge in a bucket of sea water with these other organisms.<sup>26</sup>

Fortunately, in human *Tedania ignis* dermatitis, the *Tedania ignis* toxin is suitably sensitive to the non-specific dilute vinegar (*i.e.* sensitive to dilute acetic acid). The 1936 suggestion of M.W. DeLaubenfels to treat human sponge poisoning dermatitis with dilute acetic acid<sup>1,5</sup> has repeatedly proven to be effective and recommended.<sup>1,5,6,7,19,28</sup> There is still a need for a prospective randomized double-blind controlled scientific study on the use of local dilute acetic acid in the treatment of human sponge poisonings caused by *Tedania ignis* (or other toxic sponges). In addition, there are no suitable explanations for the desquamation of the skin of the affected area 10 days to months after the initial sponge poisoning contact,<sup>1,5,7,28</sup> even upon using the initially-ameliorative acetic acid therapy (*e.g.*, our *T. ignis* patient desquamated approximately 20 days after toxin contact; one of Yaffee's<sup>28</sup> patients developed a new eruptive rash approximately 14 days after toxin contact; another of Yaffee's patients<sup>7</sup> developed erythema multiforme 10 days after toxin contact—both patients were *T. ignis* caribbean sponges; additionally, Southcott himself<sup>19</sup> desquamated, 21 days after a *Neofibularia mordens* toxic sponge contact).

Other therapies for human sponge poisoning, including *Tedania ignis* intoxication, have been tried with variable results, including:

- soothing lotions<sup>1,4</sup>
- antiseptic dressings<sup>1,4</sup>
- antibiotic therapy<sup>1,4</sup>
- acetic acid (dilute solutions) or vinegar<sup>1,4,7,19,28</sup>
- cold vinegar soaks<sup>7</sup>
- promethazine hydrochloride,<sup>7</sup> oral
- methdilazine.<sup>17</sup> (Tacaryl)
- pyribenzamine,<sup>7</sup> orally
- corticotropin in gel<sup>7</sup>
- hydrocortisone cream, 1%, topical<sup>7</sup>
- treatment like that for severe poison ivy dermatitis<sup>8</sup>
- carbolic oil,<sup>19</sup> local
- zinc oxide cream, topical<sup>19</sup>
- phenobarbital, oral<sup>19</sup>
- diphenhydramine<sup>19</sup> (Benadryl)
- flumethasone pivalate, 0.02% (W/W), topical<sup>19</sup>
- betamethasone 17-valerate, 0.1% (W/W)<sup>19</sup> (Valisone)
- topical application of steroids.<sup>19,28</sup>

The composition of the recommended "soothing lotions"<sup>1,4</sup> is not known, so it is impossible to indicate whether one ingredient was effective or not, in the absence of suitable controlled scientific clinical studies. Certainly the use of

corticotropin in gel,<sup>7</sup> topical 1% hydrocortisone cream,<sup>7</sup> topical 0.02% flumethasone pivalate,<sup>19</sup> topical 0.1% betamethasone 17-valerate,<sup>19</sup> and topical 0.05% flurandrenolide cream (our case)—indeed, any topical application of steroids—is controversial in *Tedania ignis* sponge poisoning. Our case and other *Tedania ignis* sponge poisoning dermatitis cases<sup>7,28</sup> were either not helped or made worse with topical steroids. Southcott's *Neofibularia mordens* dermatitis case (HWR) was made worse with flumethasone pivalate,<sup>19</sup> and Southcott himself felt that betamethasone 17-valerate did not ameliorate his own stings by *N. mordens*.<sup>19</sup> In contrast, Yaffee and Stargardter reported that 2 or 12 (*i.e.* 17% of) human subjects found 1% hydrocortisone cream to soothe their experimental *T. ignis* dermatitis.<sup>7</sup> In the absence of suitable controlled clinical data, it can only be stated that certain steroids (*e.g.* 1% hydrocortisone cream) were effective in two reported cases,<sup>7</sup> were not helpful 12 cases,<sup>7,28</sup> and were possibly harmful in one case, of *Tedania ignis* sponge poisoning. It is unknown if steroids are ineffective or aggravating in circumstances of human sponge poisoning from sponges other than *Tedania ignis* and *Neofibularia mordens*. In general, suitable prospective scientific studies on steroid use in human sponge poisoning dermatitis are needed.

As to the use of the H<sub>1</sub> histamine-receptor blocking antihistamine medications for *Tedania ignis* sponge poisoning in man, neither pyribenzamine (only 1 case)<sup>7</sup> nor diphenhydramine (only one case—herein) were effective. A clinical study of suitable sample size is needed. Southcott's patient responded very well to diphenhydramine after a *Neofibularia mordens* sting,<sup>19</sup> but did not respond to zinc oxide cream of phenobarbital.<sup>19</sup> Zinc oxide cream and phenobarbital have not been strongly advocated, however, for *T. ignis* stings. Human response to H<sub>1</sub> receptor-blocker antihistamine therapy may be species-specific for the toxic sponge species, and scientific evaluation is needed. The effects of the H<sub>2</sub> histamine-receptor blocker antihistamine medications, such as cimetidine, have not been tested.

The effects of phenothiazines, such as promethazine<sup>7</sup> and methdilazine,<sup>17</sup> are variable in human sponge poisoning, and prospective trials are needed.

The use of local carbolic oil (*i.e.* phenol)<sup>19</sup> does not appear to be effective, and is not recommended.

Antibiotic therapy should not be used until the wound is known to be infected and has been cultured. Sponges are known to produce many types of antibiotics,<sup>27</sup> and these may alter the bacteria flora present. In general, the fresh sponge poisoning dermatitis wound should be thoroughly cleansed, and kept clean until complete resolution. The fact that sponges produce many organified halogen compounds<sup>27</sup> (*e.g.*

bromine) should not preclude the use of povidone iodine, tincture of iodine, or alcohol solutions for wound cleansing (unless there is a known patient allergy to iodine, alcohol, or povidone-iodine), but prospective studies are needed.

Sponge poisoning to the degree of anaphylaxis or an anaphylactoid reaction should be treated as recommended for anaphylaxis.<sup>17</sup> There is no present contra-indication to steroid use in sponge poisoning anaphylaxis (but this has not been thoroughly studied). Yaffee and Star-gardter, however, have reported the only case of resuscitation for a human *Tedania ignis* sponge poisoning anaphylactoid reaction, and effectively used "epinephrine and steroids for relief."<sup>7</sup>

### Summary

In summary, the most effective current therapy for human *Tedania ignis* sponge poisoning dermatitis is dilute vinegar (2 tbs/liter) or dilute acetic acid soaks of the affected part(s), several times a day, for 5 to 30 minutes, until the wound resolves. Sponge spicules may be removed prior to the soaks, with adhesive or cellophane tape. The wound should be examined for signs of infection. An infected wound should be cultured (many species of bacteria are found in the marine waters, including *Staphylococcus aureus*, *Streptococcus faecalis*, *Pseudomonas aeruginosa*, *E. coli*, *Proteus mirabilis*, *Enterobacter aerogenes*, and alpha/beta/gamma streptococci<sup>29</sup>). Five percent acetic acid compresses are effective in reducing infections involving *Pseudomonas aeruginosa*.<sup>30</sup> The patient should be advised that skin of the affected area may peel. The physician should recollect that erythema multiforme can occur 7-14 days after the stinging episode, as well.<sup>7</sup>

The office of laboratory diagnosis of human sponge poisoning dermatitis is relatively simple (see Table 1.)

1. Confirm the history of victim contact with a yellow, orange, yellow-orange, red, red-orange, reddish-maroon sponge in the marine environment (if the sponge is preserved in formaldehyde, it will be red, orange, yellow, ivory or white; if dried out, it will be light yellow, light yellow-green, ivory, or white);
2. Confirm the acute manifestations of the patient contact: sting, erythema, burning, itching, edema (delayed manifestations 2-3 days after contact include erythema, edema, itching, vesicles; late manifestations include exfoliation or desquamation; erythema multiforme can occur; anaphylactoid reactions can occur);
3. Inspect the fresh contact dermatitis with a magnifying glass to locate sponge spicules;
4. Biopsy skin, as indicated (consultation with a dermatologist is advised before any biopsy of hand or finger tissues);

TABLE 1.—Steps In Physician Diagnosis Or Human Sponge Poisoning Dermatitis

#### EVALUATION OF THE PATIENT

1. confirm signs & symptoms
2. document sponge contact site(s) on skin
3. inspect dermatitis sites for sponge spicules
  - a. use magnifying glass
  - b. photograph, if desired
  - c. scrape or scotch-tape spicules onto microscope slide
  - d. photomicrograph slide, if desired
4. biopsy skin site(s), only as indicated
5. apply local dilute vinegar as therapeutic trial (but not at biopsy site)

#### EVALUATION OF THE SPONGE

1. **use gloves to handle specimen; wear protective glasses; work using fume hood or in well-ventilated area**
2. photograph specimen, with metric ruler & labeling
3. **do not directly touch sponge**
4. place few cc sponge in sturdy glass container
5. add 1-5 cc conc. nitric acid (HNO<sub>3</sub>) per cc sponge
6. acid digest sponge for minutes to days (**avoid exposure to vapors**)
7. carefully pipette 1 drop digest onto clean microscope slide; apply cover slip
8. scan microslide drop for sponge spicule **jackstraw appearance**
- C. 1. all residual sponge should be kept in tightly covered sturdy glass containers in the dark
- D. 1. examine gross sponge specimen for "crumb of bread" appearance
2. document sponge color(s)
3. document other sponge characteristics
  - pore sizes
  - coating
  - substrate
  - smell/odor (**avoid vapors**)
- E. 1. compare sponge to reference collection (e.g. Bishop Museum, Honolulu)
- F. 1. have sponge speciated by a sponge expert

5. Provide therapeutic trial of vinegar or dilute acetic acid as a soak or compress to the affected area;
6. Preliminarily evaluate the incriminated sponge specimen (if available):
  - a. **DO NOT DIRECTLY TOUCH SPONGE—USE GLOVES; WEAR PROTECTIVE SAFETY GLASSES;**
  - b. Place a few milliliters of the suspect sponge in a glass container;
  - c. Carefully add 1-5 ml. of concentrated nitric acid (HNO<sub>3</sub>; preferably done in a fume hood or outdoors) per ml. approximated volume of sponge, to digest the sponge;
  - d. Let nitric acid sponge mixture sit for minutes to hours to digest;
  - e. Carefully pipette 1 drop of digest mixture onto a microscope slide, and cover with a cover slip (the cover slip must cover the entire flattened drop on the slide);
  - f. Scan digest for sponge spicules under microscope low or intermediate power.
  - g. Keep sponge specimens in a very tightly sealed glass container (*T. ignis* specimens may be also stored in formaldehyde or methanol in a dark place



but color bleaching eventually transpires);

- h. Examine gross specimen for the "crumb of bread"<sup>3</sup> appearance of *Tedania ignis* (actually, many sponges have a crumb of bread appearance, grossly);
  - i. Document color of sponge specimen;
  - j. Document other sponge specimen characteristics, such as pore sizes, coating, substrate adhered to;
  - k. Compare sponge to a reference sponge collection, such as the Bishop Museum Hawaiian sponge collection;
7. Have sponge identified by a sponge expert.

Although reports of human *Tedania ignis* sponge poisoning dermatitis are not common, even in Hawaii, the actual incidence may be higher than expected. *Tedania ignis* dermatitis should be included in the differential diagnosis of marine sting afflictions, particularly those associated with the marine occupational or recreational exposures.

Sponge specimens washed up on shore after storms should be left alone, since the debris on-shore may include the fresh red-orange toxic *Tedania ignis* sponge or the sun-bleached (white) *Tedania ignis*. In general, red-orange Hawaiian sponges should be left alone, especially those growing around piers and pilings in the marine habitat.

Several toxic sponges remain toxic after the sponge has dried out (including our specimen). Also, some dried toxic sponges remain toxic for years (e.g. our specimen has remained toxic for over 15 months; see Southcott<sup>19</sup>). Our specimen of red-orange sponge in fluorescent light bleached into an ivory-white color in several months; however, one of us (JKS) allowed a *Tedania* to bleach from red-orange, into white, in 6 hours of direct sunlight. White *Tedania ignis* should still be carefully handled pending further evaluation. The evaluation of Hawaiian sponges for potential cancer cell growth inhibitors, such as the red Maui sponges,<sup>31</sup> will require special handling techniques, should *Tedania ignis* be collected intentionally or inadvertently. Aqueous, alcoholic, and other extracts of *Tedania ignis* should be handled with great care . . . the specific chemical nature of the tedaniatoxins are unknown and there are no specific antidotes at present.

## Conclusion

### A case of human sponge poisoning dermatitis

has been described in detail herein, and is tentatively attributed to the red-orange Hawaiian sponge *Tedania ignis* (Duchassaing & Michelotti, 1864). The dermatological manifestations compare favorably with 15 published human *Tedania ignis* stings,<sup>3,7,28</sup> including a report of one previous case from Hawaii.<sup>3</sup> To date, erythema multiforme and anaphylactoid reactions have been reported elsewhere, but not in Hawaii.

Our patient responded well to dilute vinegar soaks, the non-specific treatment of choice for *Tedania ignis* sponge dermatitis. No antitoxin or toxoid is currently available for the treatment of *Tedania ignis* sponge poisonings. Various steroids and antihistamines (of the H<sub>1</sub>-receptor-blocker type) do not appear to be effective against the toxic reaction . . . in fact, steroids may be contraindicated. Prospective human clinical trials will be needed, after suitable animal experimentation, to determine the optimal effective therapeutic management of this disorder, including prevention of the late exfoliative skin desquamation. The nature of tedaniatoxins are of interest because of *Tedania ignis* sponge poisoning dermatitis and its cytotoxic nature. The antimicrobial, neoplastic, antineoplastic, neuropharmacological, and psychopharmacological potential of *Tedania ignis* toxins remain to be fully explored.

## Acknowledgements

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## “What You Give Away, You Keep Forever”

CHARLES S. JUDD, JR., M.D., *Honolulu*

● *Almost ten years have elapsed since the death of one of Hawaii's great surgeons, Dr. Rogers Lee Hill, (1905-1969). On March 31, 1979, a number of his old friends and pupils gathered together to pay him tribute.\* Herewith are some anecdotes and reminiscences recounted that evening by one who knew and admired him.*

FIG. 1.—Dr. Rogers Lee Hill



The mention of Dr. Rogers Lee Hill brings a glad feeling to all physicians who knew him. De-

spite the tragedies of the final years of his life, he is remembered by us with fondness, for his genius, his generosity in teaching, his curiosity, and his laugh. Recently in California, I encountered Dr. Bradley Aust of San Antonio. He had been one of our visiting professors about 1967. The first name he mentioned in recalling his surgical associations in Hawaii was that of Dr. Hill.

We were lucky to have had Dr. Hill in our medical community. His arrival in Hawaii resulted from the efforts of two men. Dr. Jay Kuhns wanted a *locum tenens* for his practice on Kauai. He wrote to his old friend from Washington University days, Dr. Barney Brooks, chairman of the department of surgery at Vanderbilt University. The year was 1933, in the depths of the Depression. Jobs, even medical jobs, were scarce. Dr. Brooks sent Dr. Hill, his most recent chief surgical resident, to Dr. Kuhns.

By another turn of events, Dr. Hill might have stayed in the South and become a professor in a medical school there, as did two of his friends with whom he trained, Drs. Alfred Blalock and Tinsley Harrison. But he took to Lihue, and soon endeared himself to the people there. Mothers whom he delivered named their babies after him. He found and married Eunice Rice, and this was the beginning of a happy union of many years and five children.

The challenge of surgical practice in a larger community brought Dr. Hill to Honolulu in 1936, and he opened an office in the Alexander Young Building. After service in the Navy in World War II, he returned in 1945 and became the instructor in surgery that many of us remember so well. His golden years of teaching encompassed the next two decades.

Medicine for him was a way of life. Though very aware of fiscal realities and economic opportunity, as evidenced by his interest in the stock market, he was not inspired toward a large

\*Present at the gathering on March 31, 1979, were the following: Manuel Abundo, William Boyar, Roger Brault, Albert Chun, Victor Hay-Roe, Robert Hunter, Harold Johnson, Charles Judd, Ivar Larsen, Gabriel Ma, Thatcher Magoun, James Marnie, Andrew Morgan, Kazushi Tanaka, Benjamin Tom, Ignacio Torres, and Verne Waite. Accepted for publication April, 1979.

surgical practice where he would see a maximum number of patients. If he had a sick patient on his service, on the other hand, he would research the case until he had exhausted all the available medical knowledge pertinent. This was true in the case of the patient with the stab wound of the heart in 1949, upon whom he and Dr. James Marnie operated. At the successful conclusion of that case, he had a bibliography of articles on stab wounds of the heart probably second to none in the world. He was somewhat like Halsted, who became so interested in the literature in preparation of a presentation, he would stay up all night reading articles, and had to ask one of his assistants to give the lecture the next day, because he was too tired to appear himself.

Dr. Hill's office was a forum for thinking and discussion. Many of his colleagues, like Philip Arthur, Harold Johnson, Henry Gotshalk, and Gilbert Halpern, remember dropping in at noon. The conversation might take any direction, from sports, to contemporary medical problems, to history or politics. But you could be sure that you would take home some pithy principle or fact that would prick your thoughts and curiosity for several days.

FIG. 2.—Dr. Henry C. Gotshalk



Frequently he handed out mimeographed sheets dealing with various subjects at the Queen's Hospital Tuesday surgical conferences. The topics were varied and provocative, often relating to the history of medicine, but with contemporary significance. He even produced one, "The Story about Christmas," on red and green paper. Several of his peers refused to take him

seriously; they could not recognize his perspicacity. They were too busy with the pragmatic aspects of surgical practice, and the getting on with making a living in medicine. They listened to him, but they did not hear him.

Occasionally, however, the medical community did utilize his talents effectively. He was elected president of the Honolulu County Medical Society and the Territorial Medical Association. His presidential address to the Honolulu Surgical Society in 1949 was a masterpiece, and I would like to quote part of it:

"We should never lose sight of the fact that we belong to the healing art, and our primary objective is to save and prolong life, restore function, and relieve pain. In fulfilling this objective, kindness and compassion should be practiced at all times. This important phase of surgical training has been sadly neglected, and one is impressed daily with the mechanical attitude and the lack of the warm physician-patient relationship that was so characteristic of medicine in the past."

In teaching residents on a one-to-one basis, Dr. Hill had a unique way of making the resident feel important, while at the same time he was subtly engineering the course of surgery. As a resident for two years, I am sure I antagonized some of the attending surgeons at Queen's. Except for assigning cases to Dr. Lester Yee, I put most of them on the service of Dr. Hill. I felt I could not afford not to have his guidance and direction, especially if it were a complicated case. My most maturing experience was not the triumph of a successful Whipple resection or a "commando" head and neck operation. On the contrary, it occurred after we had done a lobectomy for bronchiectasis on a 14-year-old girl. All lobes were diseased, and the operation was fraught with bleeding and difficult dissection. Unfortunately, her pulmonary reserve was meager, and she succumbed soon after the operation was finished. I looked around for Dr. Hill to help me talk to the patient's family. He had left, and I had to break the news to them alone. I am sure that he left deliberately so as to force me to face this problem that every surgeon must face. On that day I grew up.

But this is not meant to be a eulogy, and Dr. Hill would be the first one to want us to have some laughs at this party. He always remembered Dr. Fred Collier's statement that "the secret of life is not to lose your sense of humor."

In that connection, I would like to relate two experiences that some of us shared with Dr. Hill, both of which had their humorous aspects. In 1963, after 15 years of bouts of diarrhea due to diverticular disease, he developed a left lower quadrant abdominal mass. He feared he might have a neoplasm, so he asked Dr. Carl Mason and me to perform a sigmoid colectomy on him. His



FIG. 3.—Testimonial dinner by his residents for Dr. Hill, December, 1956. L to R: Mitchel, Judd, Chuin, Oakley, Omura, Dr. Hill, Marnie, Morgan, Lam; Standing: Sasaki, Hay-Roe, Batten, Mason, Yokoyama, and Cherry.



bowel preparation began five days before the operation, with a clear liquid diet. He said he got so hungry he would suck on hard candy to get energy. When we resected his bowel, it was clean as a whistle.

Just before Dr. Clifford Chock gave him the anesthetic he said, "I think you boys had better put in a gastrostomy tube, in case I get distended postoperatively."

Now I hate gastrostomy tubes. In fact, I hate any artificial entry into the gastrointestinal tract that is not absolutely necessary. But a suggestion from an attending, especially my former chief, I have always felt, was a mandate or a command. I guess I felt a little the way Dr. Pat Burgess felt when he operated on Dr. Joseph Strode for acute appendicitis in 1949. The story has it that just before the induction of anesthesia, Dr. Strode said, "Burgess, you're going to make a right rectus, aren't you?"

Pat's retort was, "Hell, no! Anything I can't do through a McBurney, I'm not going to do."

Well, as the surgeon in charge, I did not do a gastrostomy. Instead, I taped a red rubber catheter to Dr. Hill's epigastric skin and brought it out through the dressing and put a Baxter clamp on the end of it. When he woke up, he said, "I'm sure glad you put that tube in my stomach."

I did not let on a thing, nor did Carl Mason. Three days later the tube fell out when a nurse

was changing the dressing. But he had already passed gas by that time, so the need for the tube was non-existent. He took the joke well and had a big laugh over it. On the 4th postoperative day, we ordered a full liquid diet for him. He was unsure as to whether his gut was ready to absorb fluids as yet. They served asparagus soup for lunch that day. About 2 hours after lunch, a joyous shout emanated from his room. He had voided, and his urine had the characteristic order of asparagin; he knew then that his gut was working.

Another adventure that I enjoyed with Dr. Hill was a trip to Chicago in the fall of 1964. At the congress of the American College of Surgeons he and I put on an exhibit entitled, "The History of Surgical Instruments." Many of you are familiar with it. Dr. Hill took his chief resident at the time, Dr. Manuel Abundo, to the meeting as his guest. This was a typical example of his generosity.

Out of the 10,000—registrants at the meeting, a number of curious surgeons sought out our exhibit. Many of them were outstanding professors who had an eye for history. Some of them became visiting professors to our Honolulu surgical program later, primarily on the basis of that meeting with Dr. Hill. Such a man was Dr. Jack Byrne of Boston University. It was interesting to see the give-and-take between Dr. Hill and such

men as Dr. Truman Blocker, the burn specialist from Galveston; Dr. Geza de Takats, the vascular surgeon of Chicago; Dr. Amos Koontz, an au-

FIG. 4.—Dr. Amos Koontz and Dr. Hill (note orchids)



thority on hernia from Baltimore; Dr. Charles Mayo III; Wesley Shaw, former resident in our program; Dr. A. A. Strauss of Chicago; Dr.

FIG. 5.—Dr. Charles Mayo III and Dr. Hill.



James Kirtley, Dr. Hill's close friend from residency days in Nashville; and Dr. Henry Harkins of Seattle. I had known Dr. Harkins for 4 years, and had often pondered his resemblance to Dr. Hill in stature, philosophy, and generosity. It was interesting to see a symbiosis occur as these two men discussed the Edwin Smith Papyrus, or whether the *Fabrica* of Vesalius demonstrated the ilio-pubic tract. They corresponded thereafter, and found out they were both "members of the 1905 Club," as Dr. Harkins put it. (Ed. Note: i.e., born in 1905.)

I ordered 100 vanda orchids to be sent to Chicago. We had them on a shelf in our exhibi-



tion case. When any lady, aged 8 to 80, came to the exhibit, Dr. Hill would reach for an orchid and pin it to the lady's lapel. For many of them, it was their first gift of an orchid, certainly their first gift of a Hawaiian orchid. Knowing he had these ladies in a dither of excitement and receptivity, Dr. Hill would lean over and say to them, "You know, there's a little dividend that goes with the orchid." And he would proceed to give them a kiss on the cheek.

The Campbell Soup Company had a booth where pretty 20-year-old girls served hot soup to the visitors. When some of these sirens found out about our orchids, they flocked to our exhibit and Dr. Hill had a field day.

After that meeting, we enjoyed visits with Dr. Hill's son, Bob, in college in Missouri, and daughters, Mary Anne, in Tucson, and Martha Lee, in Los Angeles.

One interest of Dr. Hill was aphorisms. He liked Satchel Page's, "Don't look back; somebody might be gaining on you," and Grantland Rice's, "It's not whether you win or lose, but how you play the game that counts," and this one, from George Burns, I believe, "Money is good for the nerves."

In 1965, on seeing the direction taken by many of America's youth, he evolved a saying of his own, "What we are giving our children is something we never had, and what we never had was the thing that made us great." Perhaps the aphorism he liked best of all, however, and certainly one that could be applied to his own attitude, was this one from Axel Munthe, the Swedish physician, "What you keep to yourself, you lose, and what you give away, you keep forever."





## Cut Medical Costs in Half!

A wag said, "You can cut the cost of health care by 50% with a single stroke: exempt all health personnel and facilities from taxes, on the condition that they reduce their charges by that amount."

This suggestion arises from the simple fact that about half of every dollar handed to a cashier at the doctor's office, or the hospital, or the pharmacist ultimately finds its way to the government through direct and indirect taxes. Removing these taxes would cut costs by a like amount, which, when passed on to the consumer, would really save some dough!

When a patient pays ten dollars at my office, we send three bucks to various tax collectors and spend the rest to run the office. Each employee, in turn, sends about 35% of his or her salary to the IRS and the State, and so do our landlord and our suppliers. It's easy to calculate that five out of every ten bucks we collect goes for taxes, and it's time government accepted its share of the blame.

So, if health facilities and their employees were exempted from federal, state, and local income taxes and Social Security, almost half of the cost of health care could be eliminated. This would be no windfall for any of us or our employees, because take-home pay would remain the same. The measure would simply eliminate the cost of those armies of middlemen who collect the taxes, transfer the funds to HEW, thence through Title XVIII and XIX, to filter back down through Aetna and HMSA to those of us who provide the health care.

I'd be glad to cut my fees by half, in exchange for a total tax exemption. (Business would boom!) The people would see that nearly half of "soaring medical costs" results from soaring taxes.

Of course, when you think about it, nearly half the cost of *everything* results from taxes. Imagine the economic impact if this exemption were applied to all the nation's business and in-

dustry: "All Goods and Services—Half Price." Goodbye recession; goodbye unemployment; goodbye bureaucracy!

## Don't Forget the Magic

A study showed that 85% of patients leaving a doctor's office "felt better" after consulting their physician, before receiving any medication or treatment.

In fact, 50% of patients in the waiting room already "felt better" in anticipation of their healing encounter with the physician. More surprising, 25% of patients even "felt better" once they had called for an appointment to see the doctor!

This is heady stuff. The therapeutic effect of the patient's visit with you commences long before he arrives at your office.

Sometimes we get so involved with the science of our craft that we forget that witch doctors and quacks are often as effective as we. for at least 3,000 years, patients have been cured by (and sometimes in spite of) their doctors who, until very recently, practiced wholly without benefit of a shred of scientific medicine.

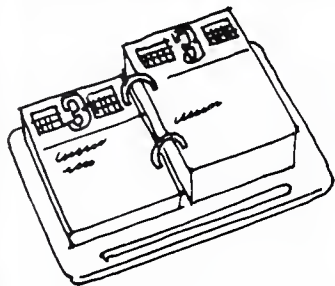
Even today while chiropractors, iridologists, and naturopaths have nothing to offer but strokes and sympathy, these charlatans thrive. Magic alone is powerful!

Science, without a little magic, is relatively powerless. As we are beleaguered by various political and economic forces, let us take a tip from our unschooled competitors and get back to basics. Let us consciously employ the overwhelming therapeutic power of our concern, our touch, our support, and our reassurance. Take an extra moment for the magic; it's very good Medicine.

JMC



"A little more anesthesia, Nurse!"



## Continuing Medical Education

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##### John A. Burns School of Medicine

1. Dept of Medicine
  - A. Case Conferences, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - B. Grand Rounds, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
  - D. Hematology-Oncology Grand Rounds, First, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
  - E. Cardiology Grand Rounds, Second and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
  - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
2. Division of Nuclear Medicine
  - A. Technical aspects of Nuclear Medicine, Second Tuesday, 5:00-6:30 p.m., Queens University Tower, Room 413, 1½ credits.
  - B. Rounds, Fourth Tuesday, 5:00-6:30 p.m., Queens University Tower, Room 413.
3. Dept. of Obstetrics and Gynecology
  - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
  - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
  - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
  - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.

- B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
- C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
6. Dept. of Psychiatry (resumes in September)
  - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
  - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room II).
7. Dept. of Surgery
  - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
  - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
  - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
  - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., University of Hawaii, Manoa Campus, BioMed Building, Room T-210.
9. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

##### Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. 3rd or 4th Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.



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- Design flexibility and cost savings

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### Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.  
(Contact H.P. Stern, Capt, M.D., MC at 449-9742)

### Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

### Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

### Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.

4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.

First—Didactic Presentation

Second—Perinatal-Neonatal Topics

Third—Obstetrics Topics

Fourth—Gyn Topics

5. Tumor Brd.—Oncology Conf. 1st & 3rd Fri. 1-2:00 p.m., Aud.

### Kuakini Medical Center

1. G.I. Conference, 1st Tuesday, 8:00-9:00 a.m.
2. Nephrology Conf., 4th Wednesday, 8:00-9:00 a.m.
3. Oncology Conf., every Thurs. 7:30-8:30 a.m.
4. Surgical Conf., 1st, 2nd and 3rd Fri., 12:45-1:45 p.m.
5. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 12:45-1:45 p.m.
6. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, 1:00-2:00 p.m.
7. Gynecology Departmental Mtg., 4th Wednesday, 1:00-2:00 p.m.
8. Pulmonary Conf., 4th Thursday, 1:00-2:00 p.m.

### Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., 3rd Mon., 7-8:00 a.m.
4. Diagnostic Radiology—4th Tues., 12-1:00 p.m.

### The Queen's Medical Center

1. ENT Conferences, 1st and 2nd Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, 4th Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, 4th Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, 2nd Tuesday, 4:30 p.m., Kam Auditorium.

Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

### St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. Sullivan 4-classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. Sullivan 4-classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. Sullivan 4-Classroom.
6. SFH-UH Hematology Conf., 3rd Thurs. ea. mnth. 12:30-1:30 p.m. Sullivan 4-Classroom.
7. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. Sullivan 4-Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.
9. SFH-UH Pulmonary Conf. 2nd & 4th Wed. ea. mnth. 12:30-1:30 p.m., Sullivan 4-classroom.

### Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the 4th Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.



"We Bring People Together"

### PERSONNEL-ITY OF THE PACIFIC

Dear Doctor:

A wise old physician once said to me of his chief medical assistant, "I think of Mrs. Lee as the Alpha and the Omega of my practice. She's the first and last contact with my patients. The manner in which she treats my patients reflects a little radiance in the office and upon me."

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Right out of the same applicant pool that also provides the terrible, the so-so, and the ones "too good to fire, to sorry to keep".

But, while there's always an element of luck involved in selecting a medical assistant, your odds of making a good choice will be better if you keep in mind the Professionals in the Medical Division of Personnel-ity of the Pacific.

Acting as your Personnel Administrator - we will advertise, prescreen, test, and interview prospective employees, reducing the time you spend with the applicant to a final interview in your office.

Call our professionally trained staff for clerical or medical assistants, permanent or temporary additions and replacements to your staff.

Allow our Professionals to work for you.

Sincerely,

*Paul S. Isenburg*  
Paul S. Isenburg, PhD.  
Director  
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686

3. General Surgery Conference meets 1st, 2nd & 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the 4th Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the 1st Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the 3rd Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the 4th Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the 1st Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the 2nd Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the 2nd Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the 4th Thursday of each month from 7:00-8:00 a.m. in the DDR.

#### Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

#### Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 5:00 p.m. dinner meeting & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: 1, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

### SPECIAL EVENTS

- |                  |  |
|------------------|--|
| Oct. 5-6, 1979   | "Update in Ostomy Care," Cancer Centr. of HI, Am Cancer Soc, HI Div., & John A. Burns Schl. of Med. Ala Moana Htl., 2 days, 9½ cred. CME Cat. I.                 |
| Oct. 8, 1979     | HI Thoracic Society—Annual Mtg. 7:00 p.m. Fireside Chat, 7:30 p.m. 2 hrs. CME Cat. I—Ilikai Htl. Honolulu. Contact: R. Respicio (808) 537-5966 for further info. |
| Oct. 8, 1979     | "Skin Cancers & Wrinkles," Spec. Seminar. 7:30-10:00 p.m. Australia Rm., Ilikai Htl. HMA/Hono. Med. Grp. Research & Ed. Found. 2½ hrs. credit Cat. I.            |
| Oct. 8, 12, 1979 | 123rd Annual Convention-HMA/AMA Regional Mtg. Ilikai Htl. Honolulu. 5 days. Contact: HMA Office (808) 536-7702.  |
| Oct. 13-21, 1979 | Fourth Annual Body Imaging Conf. West Park Hsp. Royal Lahaina Htl., Kaanapali, Maui. Approx. 30 hrs. Cat. I.   |
| Oct. 19, 1979    | "Prescription Drug Misuse," 7:30 a.m.-4:40 p.m. Ala Moana Htl., Honolulu. Hono. Med. Grp. Research & Ed. Found. & J.A. Burns Schl of Med. 6½ hrs. credit Cat. I. |
| Oct. 20-22, 1979 | Am. Hlth. Care Directors Assoc. 9 a.m.-5 p.m. 22, 1979 AHCA/Am. Geriatric Soc. 16 hrs. Cat. I. Sheraton-Waikiki Htl.   |
| Nov. 11-16, 1979 | Am. Congress of Rehabilitation Med., Sheraton-Waikiki Htl.   |

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|----------------------|--|
| Nov. 18, 1979        | "Stroke Seminar"—7:00 a.m.-3:30 p.m. Ala Moana Htl. HI Heart Assoc. 6½ hrs. credit Cat. I.   |
| Nov. 19-21, 1979     | "Nutrition, Sex and Controversy." 6:30-9:30 p.m. Mon & Tues; 1-4:30 Wed. 10 hrs. Cat. I, no fee. Dept. of Ped., John A. Burns and Kapiolani-Children's. Contact: Wilma Schiner, Dir. of Training & Ed. 1319 Punahou St. Honolulu, 96826. |
| Nov. 24-Dec. 1, 1979 | International Seminar on Operative Arthroscopy, UCLA Ext. Serv., U of H Coll. of CME & Community Serv. co-sponsors. Kauai Surf Htl., 39 hrs. Cat. I.   |
| Nov. 27, 1979        | "Fractured Families: What Happens To The Kids," Ala Moana Htl, Hibiscus Ballroom. 8 a.m.-4:30 p.m. HMA/HCMS Aux. 7 hrs. credit Cat. I. Contact: Mrs. John McDermott—955-6004 or Mrs. John Spangler—734-2925.                             |
| Nov. 28-Dec. 1, 1979 | Update: A Review of Current OB/GYN Practice, ACOG, Dept. of CME. Hyatt Regency Htl. 15 hrs. Cat. I.  |
| Dec. 1-6, 1979       | American Medical Assn.—Interim House of Delegates Meeting<br>Robert Hobart, III<br>Director, Dept. of Meeting Management<br>535 North Dearborn Street<br>Chicago, IL 60610<br>Hdq. Hotel: S-W<br>Agent: Not appointed                    |
| Dec. 6-9, 1979       | American Medical Joggers Assn.<br>Mr. Hugh S. Ames<br>Honolulu Marathon Assn.<br>P.O. Box 27244<br>Chinatown Station<br>Honolulu, HI 96827<br>Hdq. Hotel: None selected<br>Agent: Not appointed  |
| Jan. 6-13, 1980      | Ultrasound Conference, co-sponsored by the Honolulu Medical Group, Research and Education Foundation, 18 Category I credit hours. Mauna Kea Beach Htl.   |
| Jan. 8-12, 1980      | Intensive Review of Common Allergic & Asthmatic Diseases, U of Cal., Davis, Schl. of Med. Intercontinental Htl., Maui.   |
| Jan. 12-18, 1980     | 15th International Surgical Congress (Ten Surgical Specialties) Sheraton Waikiki, 20 Category I credit hours, Pan Pacific Surgical Association.  |
| Jan. 14-20, 1980     | Estes Park Institute, Kauai Surf Htl.  |
| Jan. 19-21, 1980     | Common Obstetric and Gynecological Problems, co-sponsored by Tulane University School of Medicine, Department of Ob-Gyn, and Hawaii Section of ACOG, 15 Category I credit hours, 15 cognates ACOG.                                       |
| Feb. 1-4, 1980       | Hawaii Review, co-sponsored by the Hawaii Chapter of AAFP, with invitation to BC Chapter College of Family Physicians of Canada, and Section of General Practice, BC Medical Association.  |
| Mar. 1-8, 1980       | American Urological Association, Western Section, King Kamehameha Hotel and the Sheraton Waikiki.  |
| Mar. 18-22, 1980     | Sports Medicine, Department of Physiology, Princess Kaiulani, 18 Category I credit hours.  |
| Mar. 31-Apr. 4, 1980 | Current Concepts in Obstetrics and Gynecology, co-sponsored by the University of Washington, Dept. of Ob-Gyn and Hawaii Section of ACOG, Ilikai Hotel, 24 Category I credit hours, 24 cognates ACOG.                                     |

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### OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.





**Friday, July 6, 1979**  
**320 Ward Avenue**

#### PRESENT

Drs. Goto, Bell, Winn, Hindle, Hanlon, Chinn, Chang, Azman, Miyashiro, Miles, Fong, McNamee, Howard, McCabe, Roth, Clingan, Fu, Magoun, Mills, Kuboyama, Dang, Sia, Simmons, Mrs. Nancy Simmons, and Mr. Eric Matayoshi. HMA Staff present were: Messrs. Won, Saranchock, Leineweber, Ajifu, Ontai, and Mmes. Chang, Young, and Wong.

#### CALL TO ORDER

The meeting was called to order by President Goto at 6:10 p.m.

#### MINUTES

The minutes of the previous meeting were approved as circulated.

#### INTRODUCTIONS

Dr. George Mills introduced Mr. Eric Matayoshi from Hawaii who is presently a sophomore at the John A. Burns School of Medicine. Mr. Matayoshi will attend sessions of the AMA Student Business Section at the upcoming AMA Annual Meeting in Chicago.

#### REPORT OF THE SECRETARY

The Council reviewed the Report of the Secretary as of June 30, 1979, which indicated that HMA membership totaled 886 in comparison with June 1978 when membership totaled 880. It was noted that 1979 shows an increase in active dues waived members. Approximately 30 members were dropped either for non-payment of dues or capital fund.

#### REPORT OF THE TREASURER

The May 1979 Financial Statement was reviewed in detail and approved subject to audit.

#### UNFINISHED BUSINESS

*A. AMA Annual Meeting:* Mr. Jon Won reported that as a result of recent Council action, invitations were extended to each county society for the president or president-elect to attend the AMA Annual Meeting in Chicago on July 22-26, 1979. Representing the counties will be: Dr. Walter Chang (Honolulu), Dr. Andrew Don (Maui), and Dr. Yonemichi Miyashiro (Kauai). Since Dr. Lambeth will be unable to attend for Hawaii county, it was suggested that one of the other officers from Hawaii county be invited to attend.

#### ACTION:

**It was moved, seconded, and passed that HMA should invite one of the other officers from Hawaii County Society to attend the AMA Annual Meeting.**

*B. Membership Drive:* At the last meeting, the Council discussed a proposed membership drive which would give regular members "credit toward next year's dues for recruiting new members. Dr. Mills reported that he had presented an informal summary of the program to the AMA. AMA representatives, who were favorable toward supporting such a pilot program, indicated that the legal and financial mechanisms would need to be further studied. Dr. Mills recommended that Dr. Goto write an official letter as soon as possible to Dr. James Sammons to request AMA's consideration of the proposed program. Dr. Patrick Walsh, HCMS Membership Recruitment Committee Chairman, requested that HMA officially accept the proposed membership drive.

#### ACTION:

**It was moved, seconded, and passed that HMA accept the proposal and that Dr. Goto write an official letter to Dr. Sammons.**

#### REPORTS OF COMMITTEES AND COMMISSIONS

*A. Ad Hoc Committee on Cancer Center:* As directed by the Council, an ad hoc committee was formed to prepare background information on HMA's relationship with the Cancer Center and a formal HMA position statement. Upon reviewing the draft individually, members of the ad hoc committee felt the draft to be acceptable and requested that it be presented to the Council for consideration.

#### ACTION:

**It was moved, seconded, and passed that further Council discussion on the draft be tabled until the Ad Hoc Committee meets and reports back to the Council. There were two opposing votes.**

*B. Medical Services:* Dr. William Dang reported that a joint meeting of the HMA Executive Committee, Self-Insurance Committee, and Malpractice Law Subcommittee, which had been scheduled for June 28, 1979 for discussion with representatives of The Doctors Company of California had been canceled due to some misunderstanding in scheduling.

*C. EMS:* Dr. Dang reported that the Board of Medical Examiners has formed an ad hoc committee to discuss the possibility of the Board becoming the state body responsible for certification of paramedics; however, the committee has not had an opportunity to meet. Dr. Dang reiterated HMA's position that the Board should certify paramedics since they function as extensions of physicians. It was also reported that on May 30, the State DOH administered a MPP pilot exam (National Registry Exam) at Tripler in order to explore the possibility of it being used as a certifying examination for paramedics.

With regard to funding for the EMS Program, it was reported that the grant-in-aid ended on June 30, 1979, under the terms of the DOH-HMA contract. A letter was written to the DOH indicating that HMA would have no choice but to discontinue the program, unless word is received from the Department regarding funds for future continuation of the program. In

an effort to resolve this matter, a meeting was held on June 25 with DOH representatives at which time HMA was assured that it would receive \$375,000 to continue the program for an 8-month period.

*D. Legislation:* Dr. E. Lee Simmons reported that he, Dr. Cahill, and Dr. Goto had presented testimony for HMA at a recent House Health Committee hearing on the cost of medical care. Testimony was also presented by Dr. Mills for the Voluntary Effort program. Discussed at the hearing were issues involving independent nurse practice and hospital rate review system.

Dr. Mills also briefed the Council on hospital cost containment bills and catastrophic national health insurance bills presently before Congress.

*E. Medicaid:* Dr. Roy Kuboyama reported that the Medicaid Committee is continuing to study problems of reimbursement under Medicaid and is exploring various avenues for seeking future legislative change. Dr. Kuboyama referred to hearings held earlier this year regarding contractual relationships with physicians and the DSSH. To date there has been no decision on those proposed rules. The Council felt that HMA should work with other professional groups in this area.

*F. Chronic Disease:* Dr. Kuboyama reported that the Chronic Disease Committee met recently for the first time and promises to be a viable committee.

*G. Communicable Disease:* As a result of recent legislation in the area of premarital rubella screening, it was reported that the DOH has developed a new premarital health form (marriage license application). Since the new form seems to be confusing, the DOH will review the form with general practitioners utilizing the county medical societies.

*H. Internal Affairs:* Dr. Neal Winn reported that programs for the HMA Annual Meeting and AMA Regional CME Meeting should be received by physicians in the near future. The program is scheduled to appear in the HAWAII MEDICAL JOURNAL and further publicity is planned for HMA members.

*I. Finance:* Since it is customary for the Council to annually elect the Finance Committee, the following nominations were made by the President:

Douglas B. Bell, II  
Walter W. Y. Chang  
William Dang  
Elmer Johnson  
Calvin Sia

The following were additional nominations made by members of the Council:

Marcelino AVECILLA  
Richard Chang  
Lester Yee

**ACTION:**

**It was moved, seconded, and passed to elect the above-mentioned nominees to the Finance Committee. (The election of Drs. AVECILLA, Chang, and Yee is subject to their acceptance of the appointment.)**

Automatic members are the HMA Treasurer (as Chairman) and the treasurers of the component medical societies.

*J. Bureau of Research and Planning:* Dr. Calvin Sia reported that HMA did not get funded for the proposed diabetes project.

*K. Building:* Mr. Andrew Saranchock reported that the Building Committee met just prior to the Council and requested that the following items, which deal with the authority of the Committee under the guidelines approved by the Council in 1976, be presented to the Council:

1. The Committee requested that Council reconsider its action of the last meeting, "that staff be allowed to pursue, *up to the point of execution*, a contract with Diamond Parking, Inc." The Committee felt that under current guidelines, the contract with Diamond Parking would fall in the category of an administrative contract, with authority for approval given to the President or Executive Director.

**ACTION:**

**It was moved, seconded, and passed to rescind the action taken by the Council at its last meeting; and that staff be allowed to pursue and execute a contract with Diamond Parking, Inc. in accordance with current building guidelines.**

2. While current guidelines give the Committee the authority to execute leases, it was pointed out that the guidelines are silent in the area of termination of leases. The Committee recommended that Council be flexible in its position in allowing the Building Committee to negotiate terms of termination.

**ACTION:**

**It was moved, seconded, and passed to give the Building Committee the authority to terminate leases.**

3. The Council also agreed that the Committee pursue a revision of the guidelines, for report back to the Council, to allow for more efficient administration of building matters.

## REPORTS OF COUNTY PRESIDENTS

*A. Honolulu:* On behalf of Dr. Walter Chang, Mr. Jon Won reported that the Physicians Exchange, a HCMS subsidiary, was granted two weeks ago its own license on a special medical emergency channel for its paging service. Physicians will receive new radios within the next 3 to 4 months, and it is expected that service will be improved considerably in the way of actual communications. On September 4, the Society will hold its next dinner meeting at the Hawaiian Regent Hotel with Mrs. Betty Sullivan as the featured speaker with a presentation on, "Masterpieces in Art—Who Says So?"

*B. Maui:* Dr. Ben Azman reported that the Society will hold its seventh meeting of the year on July 17 with a presentation by Dr. Auerswald, Director of the Maui Community Center Mental Health Clinic and a film from the Mental Health Association.

*C. Hawaii:* Dr. A. Scott Miles reported that the Society will hold its next monthly meeting later this month, with Dr. Edward Montel from the Hilo Medical Group (who recently joined the Society) to speak on G.I. diseases.

*D. Kauai:* Dr. Yonemichi Miyashiro reported that the Society will hold a dinner meeting on July 12, with a pathologist, Dr. Emory, as the guest speaker. Dr. Miyashiro commented that the Society's recruitment program, on a one-to-one basis, has been quite successful.



## OTHER BUSINESS

*A. Auxiliary:* Mrs. Nancy Simmons reported that she will be a delegate at the upcoming National Auxiliary meeting and just prior to this meeting will be attending workshops on health, legislation, and AMA-ERF. The Auxiliary's direction this year will probably be in the areas of communications and legislation, and Mrs. Simmons commented that the Auxiliary would welcome suggestions from physicians on ways in which they can be effective.

*B. Hiroshima Prefectural Medical Association:* Mr. Jon Won reported that the Board of Directors of the Hiroshima Prefectural Medical Association would like to visit Hawaii at the end of December 1979 for the purpose of renewing and further developing the friendly ties with the HMA and to hold a joint session including a scientific meeting. A recommendation was made that a small committee be formed to further explore and plan for the proposed visitation and that Drs. George Suzuki, Herbert Uemura, and Henry Yokoyama be asked to participate on the committee.

### ACTION:

**It was moved, seconded, and passed to form a small committee to further explore and plan for a visitation by the Hiroshima Prefectural Medical Association.**

The Council agreed that a letter be written by Dr. Goto to invite the Hiroshima group to attend the Combined HMA 123rd Annual Meeting/AMA Regional CME Meeting in October and the AMA Interim Meeting of the House of Delegates in December. The Council felt that the committee could develop alternate plans if the Hiroshima group cannot arrange to be in Hawaii for either meeting.

*C. Request from Department of Health:* The Council discussed a July 6, 1979 letter from the DOH requesting HMA support for the State DOH's (Health Education Office) application for federal funds through the Health Education Risk-Reduction Grant Program. Since Mr. George Yuen has also asked for suggestions by HMA to make this a worthwhile program, it was recommended that this matter be referred to the Public Affairs Committee to generate ideas for report to the Council.

### ACTION:

**It was moved, seconded, and passed that HMA support the DOH's application for funds to establish a Health Education Risk-Reduction Program; and that this matter be referred to the Public Affairs Committee.**

*D. Request from Representative Herbert Segawa:* In a recent letter from Representative Herbert Segawa, HMA was informed that Mr. Segawa would like to invite Dr. Kenneth Cooper to Hawaii for a series of talks on the concepts and mechanics of his Aerobics program. The Council felt that HMA should endorse the program. It was also felt that the proposed program might be within the scope of the DOH's application for a Health Education Risk-Reduction Program, and the Council agreed that this proposed program be brought to the attention of the DOH.

### ACTION:

**It was moved, seconded, and passed to refer this matter to the Public Affairs Committee.**

*E. Per Diem Policy:* Mr. Jon Won requested that Council reconsider its per diem (travel expense) policy

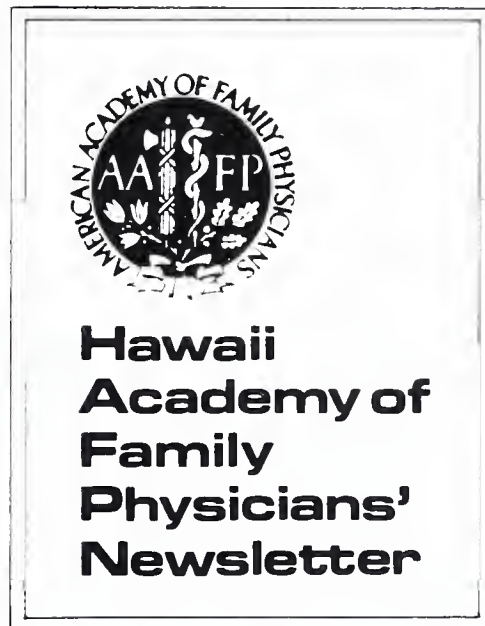
in view of the upcoming AMA Annual Meeting. Mr. Won noted that HMA representatives are traveling to areas such as Chicago and San Francisco where the minimum room rate for single occupancy is \$60-65 plus 8.1% tax. Inasmuch as a certain amount is allowed for meals and gratuity, it was pointed out that HMA's current policy of \$75 per day would not include this allowance.

### ACTION:

**It was moved, seconded, and passed that the per diem allowance cover the hotel room expense plus \$25.**

## ADJOURNMENT

The meeting was adjourned at 8:45 p.m.



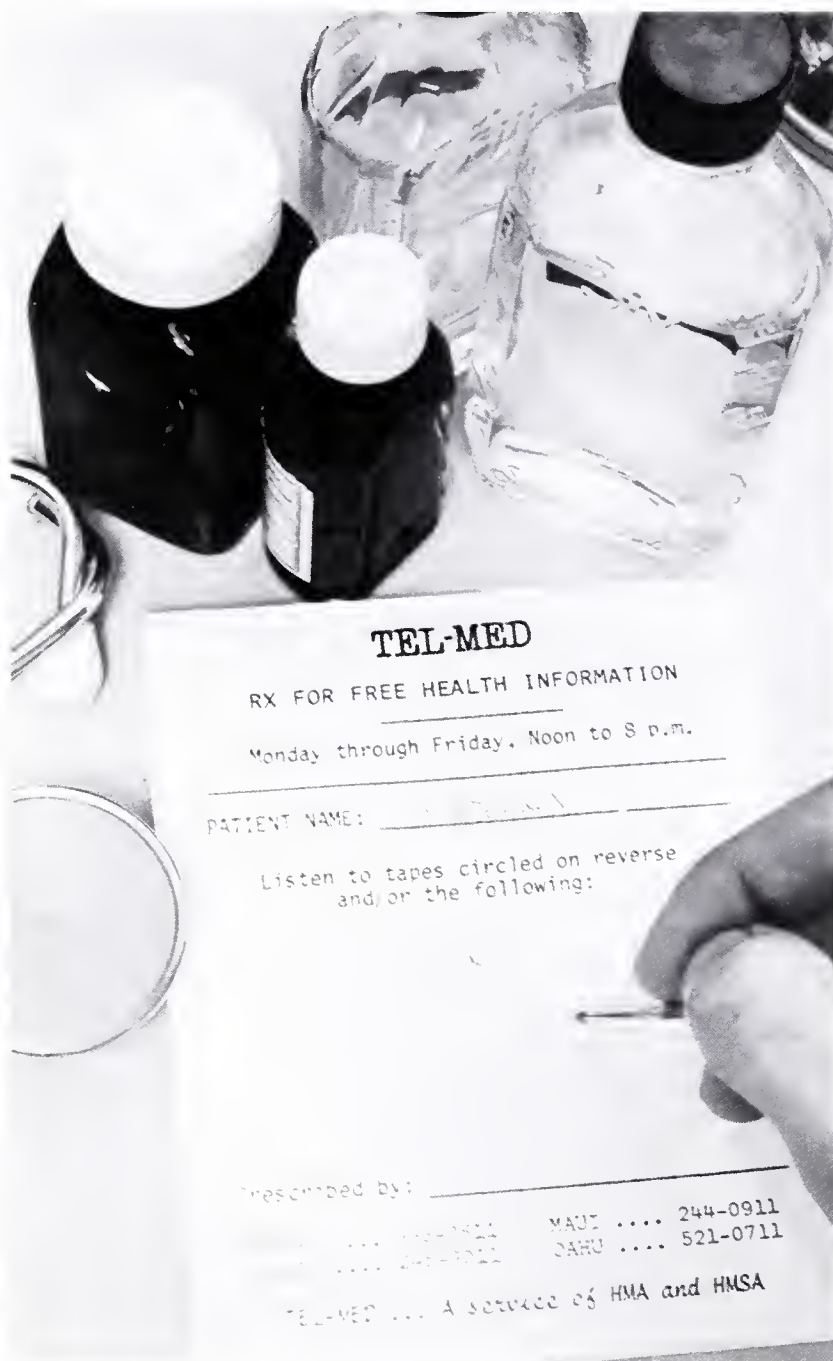
**New Members**—Six, yes 6 new members joined us this past month! **Paul T. Esaki MD**, formerly a Student member at UHSM, now returns as an Active member situated in Eleele, Kauai. **Herbert R. Estis, Jr.** has joined Kaiser Permanente and is a new Active member. **Anthony Francis Firek** is a new Student member from the UHSM '81. **David R. Gilmour** is a new Resident Affiliate member in the Family Practice program at Kaiser. **Joseph P. Hennessy, Jr.** is a new Active member on Maui (Maui Clinic). **Charlie Joe Talbert, Jr.** is a new Practicing Affiliate member as an intern at TAMC. Welcome!

**Dropped**—from membership is **Randolph Shiraishi MD**, former Student member who has gone into Internal Medicine as a Resident in Portland, Ore.

**News of Members**—former Student member, now **Clarissa T. Burkert MD '79** has transferred to USC (no, not the U. of Southern Calif.) which stands for the Uniformed Services Chapter of AAFP and is at Tripler. Those physician members in the Military have a choice of joining the USC or the State chapter, or both. **Tom Cahill** and **Doris Jasinski** were nominated by the Council for election to the Board of Governors, HCMS. If elected by that organization, they will represent not only the membership of HAFP but also a long list of non-member GP's who have so signified their intentions. **Doris Jasinski** has been awarded the degree of Fellow, AAFP. **Jim Tsuji** served as moderator for the Family Practice Section I of the August USC-UH-TAMC Postgraduate Refresher Course at the Sheraton Waikiki. Incidentally, despite failure to so publicize in advance, credit hours that session August 11 to 22 were "P"! Fill out your yellow cards accordingly, you members of AAFP! Phil Manning, the USC program director, is looking for speakers from our ranks for next year's FP Section; anyone interested, please apply now. Some

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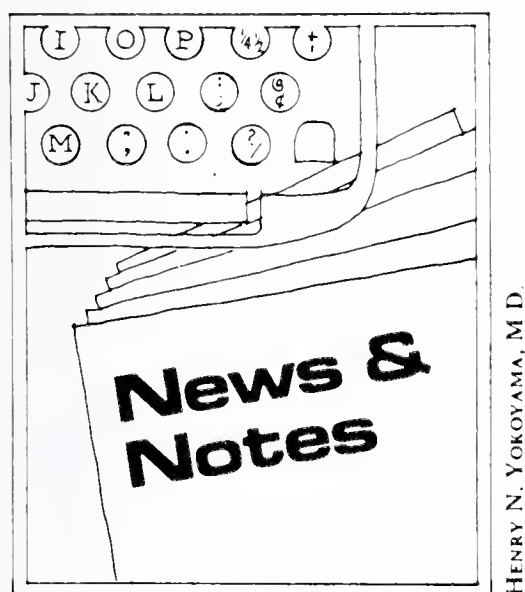


700 physicians attended the 22nd Annual Session. **Peter J. Leeson Jr. DO**, an Active member of HAFP has relocated in Selma, Calif.

**AAFP**—holds its Annual Convention and Scientific Assembly in Atlanta, Ga. October 6 to 11. Delegates from the Hawaii Chapter **Tom Cahill** and **Don Farrell** will be joined by Alternate Delegate **Jim Tsuji** and perhaps **Bob Todd** if the Military will release him temporarily from duty at Tripler. AAFP is asking for nominations to its many commissions and committees at the national level. If any member of HAFP is interested in such service, please contact our ExecSec.

**Mead Johnson Awards**—Family Practice Residents are eligible to apply for one of eighteen \$1,200 awards if they are in their second year of a FP Residency and plan to take a third year in Family Practice training.

**CME**—AAFP members please note that QMC publishes a monthly Continuing Medical Education Program which now, *in advance*, lists the programs that have been accredited as "P." One of these is the every Friday 8:00AM "Queen's-UH Med. Conf." **Pat Walsh** has relayed to us the request from Dr. Meyers for participation and case presentations by members of HAFP, and suggestions for topics of interest to Family Physicians.



## 123rd Annual HMA Convention Hi Lights

(Oct. 8 Monday to Oct. 12 Friday)

- AMA Regional CME Program Monday thru Friday Oct. 8-Oct. 12 Ilikai Hotel (See July & August issues of HAWAII MEDICAL JOURNAL) 25 hours of Category I credits available . . .
- HMA House of Delegates Annual Meeting Monday, Oct. 8, 1979 1:30 PM. Opening Session: Reference Committee Hearings Guest: Hoyt Gardner M.D. AMA President Final Session: Wednesday, Oct. 10, 1979 1:30 pm.
- Hawaii Thoracic Society Annual Meeting, Monday, Oct. 8, 1979 7:00 pm and Fireside Chat Conference, Cat. I, 2 hours, 7:30 pm.
- Sports Events: Tennis Tournament: Ken Kern chairman . . . Singles finals on Saturday, Oct. 6 and Doubles tournament on Sunday, Oct. 7 at King Street Courts  
Golf: Thursday, Oct. 11 at Leilehua Golf Course . . . Neal Winn, chairman  
Skin Diving: Kalaupapa, Molokai, Aug. 18 and 19. Limited to 8 participants  
Ping Pong: John Spangler to arrange time and place  
Deep Sea Diving: Andy Morgan to arrange time and place  
Sportsmen's Night: Thursday, Oct. 11 at Kanraku Tea House (Richard Yoshino making arrangements)

- Annual HMA Banquet: Ilikai Hotel, Pacific Ballroom . . . Friday, Oct. 12 . . . Aloha Attire . . . Kathy Goto and group to put on musical program . . .

## Professional Moves

The deluge is upon us in this seventh month of the Year of the Ram . . . We welcome all the new members to our growing medical community and wish them God speed . . . We shall start with the Kaiser Medical Program which has added internist **Thomas Nestor**, and ER physicians **Carl Hodel** and **Eric Altenbernd** . . . The Honolulu Medical Group has added internist **Gilbert Sofio**, eye man **Wayne Wilson** and bone man **Gary Douglas** . . . The Straub Clinic has added internist **Henry Preston**, ER physician **William Haning, III** . . . The Central Medical Clinic has added pediatrician **Eliot Tomomitsu** . . . Pearl City Medical Associates added allergist-pediatrician **Franklin Yamamoto** and the Medical Specialty Clinic in the American Security Bank Bldg. added gastroenterologist **Anthony Chiu** . . . Internist-oncologist **Dennis Wachi** joined the Hematology-Medical Oncology Associates at the Medical Arts Bldg.; OB man **Irwin Lee** opened at the Piikoi Medical Bldg. and urologist **Antonio Tan** opened at the American Security Bank Bldg. . . . Ophthalmologist **Gilbert Yamamoto** opened his office at the Kuakini Medical Plaza and Gynecologist-Sexual Counselor **Rick Williams** relocated to 1319 Punahou Street, Suite 920.

On the outer islands, OB man **Robert Yapp** joined The Maui Medical Group in Wailuku and **Ronald Resnick** opened his office for general and family practice at the Up-country Medical Clinic in Pukalani, Maui. On Kauai, eye man **Harold Cameron** joined The Kauai Medical Group while **David Elpern** became the first full time dermatologist on Kauai. David was in charge of the Koloa Outpatient Clinic from 1974-77 and completed a two-year dermatology residency at Johns Hopkins . . . From West Hawaii, we received news that **Terence Young** will close his office and go back for further training and **Jim Mayer** will take over his practice effective Aug. 1 . . . **A. D. Pathomvanich** opened his office at the Tebano Bldg. in Kailua-Kona between the Fujitani Store and the Latter Day Saints Church across the Bank of Hawaii . . .

There's so much adoin in August, we continue with the large clinics . . . Orthopod **Ari Uematsu** and FP's **Herbert Estis, Jr.** and **Robert Rozendal** joined the Kaiser-Permanente Medical Care Program at 1697 Ala Moana Blvd. . . . Internist **John Mickey** and dermatologists **Jay Grekin** and **Roman Glamb** joined the Straub Clinic & Hospital. The Pang Eye, Ear, Nose & Throat Clinic Inc. (L.Q., Herbert, and Meredith) added a Tam, viz **Roland Tam** who does otorhinolaryngology, facial plastic surgery, reconstructive and maxillofacial surgery . . . (With such credentials, the Pang's can overlook the fact that Tam is not just another Pang.) FP **Barry Odegaard** joined the Ala Moana Medical Clinic, Inc. at 1441 Kapiolani Blvd., Suite 415 and **Masahiro Mori** who specializes in heart disease and hypertension opened his office at King-McKinley Bldg., Suite 312. Dermatologist **Milton Ackerman** joined Norman Goldstein MD Inc. in the Alexander Young Bldg., while yet another dermatologist, **William Wong**, opened his branch office in the American Security Bank Bldg. at 1314 So. King. (Ed. That makes four new dermatologists for the month . . .)

On to the Big Island, where in Hilo, yet another dermatologist, **Timothy Knight**, opened his office at 670 Ponahawai St. and surgeon **William Rassman** (who does general, vascular, thoracic and trauma surgery) joined the Hilo Medical Group Inc. at 1292 Waianuenue Ave. In West Hawaii, internist **Jonathan James** joined the Kona Coast Medical Group, orthopod **Bernard Fogel** opened in the Tebano Bldg. at 75-5745 Kuakini Hwy., and internist-gastroenterologist **Edwin Montell** announced that he will be available for consultations on the 2nd and 4th Mondays of each month at Kona Hospital.

On the Garden Isle, local boy **Paul Esaki** returned to join the Eleele Clinic to do family practice. After finishing John Burns Medical School, Paul did a 2-year residency at the U of

Oklahoma Health Science Center. Ophthalmologist **Harold Cameron** joined Albert Ley in the outpatient department of G.N. Wilcox Memorial Hospital . . .

Orthoped **Richard Dodge** was sworn in as Honolulu's new city physician, a position which has been vacant for more than a year and neurologist **Ronald Yamaoka** of Kailua who is chief of Neurology Service at Tripler was recently promoted to Colonel.

## Life In These Parts . . .

"Pediatrician **Dr. Steven Tenby** was mistaken for someone else by a woman guest and she got terribly red-faced when he informed her, 'I take care of your kids!'" (*Dave Donnelly's Hawaii* . . .)

Four cases of Ross River fever, an exotic mosquito-borne tropical disease were seen in Honolulu, according to **Ned Wiebenga**, DOH epidemiologist. The four patients were travelers who had visited Fiji where 40,000 cases of Ross River fever were reported between January and June this year. The illness resemble Dengue Fever, is caused by a virus and may persist 9 months to a year. It starts with a rash, fever, arthritis, myositis, tendinitis, an occasional sore throat, headaches and mental disorientation. Fortunately, the carrier mosquito is not present in Hawaii. Ned says that returning travelers from Fiji with a fever resembling Dengue should consult their physicians and arrange for diagnostic testing through the DOH . . .

The St. Francis Hospital Hemodialysis Satellite Facility in Wailuku, Maui hosted 25 hemodialysis patients from California in August. The group was from the private, non-profit Satellite Dialysis centers in San Jose and Palo Alto and were being rewarded for "participating in their own care" viz prepare the hemodialysis machine for treatment and monitor the machine's activity while he is hooked up . . .

When ex-sniper Robert Miller, on leave from Hawaii State Hospital sniped at and terrorized tourists on a Waikiki Saturday in August, the question was asked, "Can mental health professionals accurately predict whether a person is dangerous?" Forensic Psychiatrist **Robert Marvit** replied, "Under some circumstances, yes. Under some circumstances, no. Under other circumstances, maybe. The best that mental health professionals can do is to make 'probability' statements." Psychiatrist **Byron Eliashof** added, "It's very difficult for mental health professionals to predict dangerousness with a high degree of accuracy. Unfortunately, we're often called upon to do this by the court system" Psychologist **John Blaylock** said, "We have no way of knowing if circumstances are going to rise that will produce dangerousness . . . There are so many factors—jobs, girlfriends, environment—we have no way of predicting if those will go well or badly." John feels that the system is far more successful than it is given credit for. "Each year, the courts, the prison parole board and doctors turn loose 600 people who are known to have done something dangerous. About once every 2 years, something bad happens in that system. To correct for that, we would have to keep all 600 locked up. The public is asking for absolute perfection when we don't have the knowledge and

skill." The solution? Robert feels that the actual decision on dangerousness should not be left to the mental health professional. It should rest with the courts. Byron Eliashof says, "The judicial system must determine who should be kept away from society and who should go free. One solution may be to impose a jail sentence after the person convicted of a crime no longer needs to be in the state hospital, rather than allowing him to return to the community."

**Mark Szasz** who has been in practice in Aiea for 4 or 5 months is 29 and already a relic . . . because he's an old fashioned doctor who makes house calls . . . Mark relates three reasons for house calls: It increases your diagnostic abilities . . . You can see the reality, the dynamics of the patient's life at home . . . You can see the actual physical set-up, whether their environment is healthy or not . . . The second reason is that people will recognize how much interest you show if you make a house call. Often it helps release a lot of tension. And thirdly, "some people just can't make it to the office. Some are too sick, some are elderly. A house call can really help you develop rapport."

## Sportsmen

One late Sunday afternoon, in August, we met an exhausted but happy **John Smith** who had just returned from a deer hunting trip to Molokai. He proudly displayed two multipointed antlers as proof of his prowess . . .

During the HMA skin diving trip to Kalaupapa, over the August 18, 19 weekend, **George Kennessey**, **Roger Ogata**, **Norman Nakashima**, and **H. Yokoyama** went night diving and were more successful than during the day. A solitary fishing boat anchored a mile or two off shore had lights which confused the divers to no end, especially when the house lights on shore all went off around 10 p.m. Fortunately, the ever faithful lighthouse beacon kept us from swimming off toward Oahu . . . Several weeks later we were discussing fishing when **Ray Fujikami** reported how **Tom Frissell**, Ray, and his wife Diane, *et al* had anchored off Kalaupapa that same Saturday night and had fished for ulua. Tom, Ray, *et al* apparently had a bountiful catch for that long weekend . . . The eight stalwart skin divers included **Bill Davis**, **Herb Uemura**, **Marc Shlachter**, **George Kennesey**, **Ed Quinlan**, **Norman Nakashima**, **Roger Ogata**, and **H. Yokoyama**. By unanimous acclaim, Norman Nakashima was voted the winner of the tournament with the most and the largest catches.

OB Gyn professor **Tom Kosasa** flew his own rented plane in with 3 OB Gyn residents, **Gary Kimata** *et al* from Kapiolani-Children's Hospital, to skin dive and sightsee for one day. A poorly secured hatch cover blew off just before Tom landed, but there was nothing to fear because Tom has been flying since his Princeton days and was a regular pilot for Skyways and flew interisland routes during his summer vacations . . .

### Marathoners:

We have the Hunky Bunch (Hunky Chun and his family) and now we have Kailua's the Motley Crew consisting of Tripler surgeon **Peter Barcia**, his wife Julie, and their 10 (?)

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children, John, 15; Amy, 14; Kathy, 12; Dan, 11; Julie, 10; Joe, 8; Maureen, 5; Maile, 3; Tony, 2; and 3-month-old Roselani. The Motley Crew has run more than 20, 26-mile marathon races, plus hundreds of assorted local events . . .

**Jack Scaff Jr.**, President, Honolulu Marathon Association discussed signs of overtraining . . . "Bloody urine has been adequately researched in the literature and is simply the next stage in the deteriorative process . . . Runners with discolored urine who proceed to bloody urine, can assume that a running injury is imminent . . . Failure to change the running program will almost certainly lead to a musculoskeletal injury of a significant nature . . . The first symptom is fatigue (discolored urine), second is pain (bloody urine), third is tenderness, fourth is swelling, fifth is death or tear of tissue . . ."

In Kailua, **Donald Guimont**, known as the "running podiatrist" and assisted by several physician runners, is looking for both new and experienced runners to join the Windward Marathon Clinic every Sunday at 7:30 a.m. at Kailua Beach Park pavilion . . .

This year's Honolulu Marathon may hit 10,000 according to Jack Scaff. "Last year we had 7,200 entrants and 6,000 starters." Pan Am came up with the idea of marketing the event and already has advance bookings for 1,250 persons, including 360 from Tokyo, 300 from Osaka, 250 from New Zealand, 100 from Germany, 50 each from Indonesia, and Australia and 25 from Taiwan. Jack says, "We've developed a system to handle 14,000 runners; now it's up to the runners to develop a system to handle themselves . . . We're looking forward to the biggest mass participatory event ever held in the State of Hawaii . . . for anything."

*Grid Injuries:* The *Honolulu Advertiser* and the John Burns School of Medicine will work jointly to reduce injuries in high school football in Hawaii in cooperation with coaches throughout the state. The Med School has established a Committee of Sports Medicine headed by **Ralph Hale**, chairman of the Dept. of OB & Gyn. Acting dean **John S. Wellington** said, "It is another example of how the school can serve the people of Hawaii and a cooperative effort like this is the finest kind of public service journalism."

## Miscellany

(Jokes told by MC **Gordon Kam** at the recent Miss Chinatown Contest)

"Mr. Butter married Miss Margarine and they had two Parkays . . ."

This is the story of how Officer Manuel became a famous policeman . . . A 300 lb. gorilla was reported terrorizing Chinatown so Sgt. Nobriga called patrolman Manuel on the radio. "Officer Manuel, there is a gorilla on the loose in Chinatown . . . I want you to get him and take him to the zoo." Officer Manuel replied bravely, "Yes sir, Sgt. Nobriga. Will do." Several hours went by and no report from Officer Manuel . . . Sgt. Nobriga gets on the radio and contacts Officer Manuel. . . "What's happening, Officer Manuel." "Well, Sir, I took the gorilla to the zoo as you suggested, and we looked at all the animals . . . We are now proceeding toward Makapuu because he want to see Sea Life Park."

One day, Patrolman Manuel was promoted to detective . . . Sgt. Nobriga wondered about Detective Manuel's educational background so he asked, "Who killed Abraham Lincoln?" Detective Manuel grumbled, "First day on the job and I get a homicide case."

## Elected, Appointed & Honored

**John Watson** who recently returned from an 18-month assignment in Pakistan, where he headed a U of H health team assisting the Pakistan government in implementing its National Basic Health Services Project, is the new medical director of HMSA . . . Internist Nuclear Med man **Richard Littenberg** is the new president of the Honolulu Medical Group Research and Education Foundation established in 1943 to promote medical research . . . Trustees include **Mort Berk, Vincent Friedewald, Norman Goldstein, Judson McNamara, Roderick McPhee**, etc . . . **John Kim** was appointed to the Board of Medical Examiners and **Elizabeth Adam** to the Intake Service Advisory Board by Governor George Ariyoshi . . . The Hawaii Heart Association elected the following physician members to its volunteer board: **Edgar Ho, Eugene Magnier, Alfred Morris**, and **James Orbison** . . . Continuing to serve as volunteer officers are **Samuel Gresham**, president, **Douglas Bell II**, president-elect, and **Irwin Schatz**, vice president . . . **Marquis Stevens**, medical director of Hawaiian Life Insurance Co. since 1965 is the only person in Hawaii to become a diplomat of the Board of Life Insurance Medicine . . . Retiring medical director of the Maui Clinic and ENT man, **Harold Kushi** was "roasted and toasted" by fellow physicians, technicians, relatives and friends at the Maui Beach Hotel in July . . . Harold was hailed by a loyal employee as "The best boss in the world!" He was variously described as "a gentleman farmer," the "Kula artichoke mayor" . . . State Health Director **George Yuen** commissioned a state EMS System Advisory Committee including physician members **Livingston Wong, Jeffrey Goodman, Sakae Uehara** and **Djon Indrea Lim** . . .

## Community News

**John Smith**, chairman of the board of directors announced that the Honolulu Medical Group will continue to offer its "Optifast" program which had stopped taking new patients during an evaluation period following the death of choral director Zillah Young, who had lost 150 pounds and died suddenly following a Honolulu Symphony concert.

The physicians at Straub Clinic have presented a collective gift of \$45,000 to the Blood Bank of Hawaii to help its new building program. **Robert Flair** Straub's chief of staff headed the effort and the presentation was made by Staub chairman, **Robert Kistner**. **Albert K.C. Chun-Hoon** is the blood bank's overall chairman of the medical division.

The Kapiolani-Children's Medical Center's department of neonatology and the U of Hawaii Medical School's de-

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partment of pediatrics have received a \$1,500 grant from Mead-Johnson Laboratories. The grant will be used to train and educate medical professionals on Oahu and the Neighbor Islands in newborn medicine with emphasis on resuscitation techniques for high risk infants.

## Hors de Combat

Excerpts from *Star Bulletin* writer Murry Engle's humorous article relating to Kaiser orthopod **Martin Wolferstan**: "She's Glad Her Life in a Cast Didn't Last." "Mybone specialist's nurse called the other day to change the date of my checkup on the mending elbow I had broken early in May . . . Seems my orthopedic specialist, Dr. Martin Wolferstan, recently broke nine ribs, his collar bone and his left shoulder in a motorcycle accident, trying to avoid hitting two dogs . . .

When I started writing this, I decided to call Dr. Wolferstan. A couple of weeks after his mishap, he was still in pain, still furious at 'whoever lets their two yellow dogs run loose in Aina Haina in rush-hour traffic . . . I swerved to miss one, but the other kept coming at me and we hit,' Wolferstan said. 'I went over the handlebars. No, I didn't lose consciousness. Wish I had. Wrecked my bike and ruined by favorite shirt, too.' After commiserating, we discussed what a remarkable instrument the human body is, with its capacity for regeneration. It actually creates new bone to replace the old. 'Tell me if I'm crazy,' I said to Dr. Wolferstan, 'but I swear, I could feel the healing sometimes—surges of energy through the whole arm, but concentrated on the fracture area.' 'Oh, yes, people say they do feel that,' the doctor said, 'No, I don't feel it yet. Arggh!'"

Elizabeth Wehr analyzes "Health's High Cost" in the Congressional Quarterly: "Americans are hooked on health insurance . . . And that addiction has caused feverish inflation in the nation's medical marketplace, according to controversial economic theory now gaining ground in Congress . . . Thirty years ago, fewer than half the nation's hospital bills were paid by 'third-party payers'—private insurance plans or public programs for the poor and elderly. Now, hospitals get more than 90% of their revenues from these payers, not from individuals . . . The lesson of the last three decades is clear to economists Alain C. Enthoven of Stanford University, Martin Feldstein of Harvard and Clark C. Havighurst, an antitrust lawyer teaching at Duke University who specializes in medical economics.

They say insurance shields consumers from the real costs of health care and reduces the incentive for doctors or hospitals to cut costs. If Americans had to pay more of their medical costs out of their own pockets, they'd exert more pressure to keep them down, the three economists say.

To put the economists' theory into practice would require some major changes. Congress would have to peel back the layers of regulations that now keep insurance companies, doctors, hospitals and others from competing for patients. And federal tax laws that now subsidize private health insurance plans would have to be revised.

On Capitol Hill, this theory is increasingly talked about as an alternative to both national and health insurance and to President Carter's hospital cost control bill . . .

But the nation's addiction to health insurance and the longevity of national health insurance as a political issue suggest that Americans still want all the financial help they can get to pay medical bills . . .

A federal grand jury returned the first Medicaid fraud indictment against psychologist **Virgil Willis Jr** on 40 counts of mail fraud and making false statements. Willis, age 45 would face a possible maximum of 200 years in prison if convicted on the 18 mail fraud and 22 false statement counts. Rick Eigchor, head of the state's Medicaid Fraud Unit estimates that Willis improperly obtained \$20,000 to \$30,000 in Medicaid funds, for the period December 1977 to March 1979.

When **Jeff Goodman** who lives in Kilauea, Kauai and practices in Kapaa requested a zoning change in Kilauea for 3 acres from R-6 zoning to commercial so he can build a medical clinic and make future plans for a hardware store, a

nursery school and a couple of "Mom & Pop" type stores, he raised a hornet's nest within the community.

Gynecologist-psychiatrist **Edwin Gramlich's** two bedroom home on Waialae-Iki ridge was destroyed by fire in July after burglars broke in and stole a coin collection. Damage was estimated at \$125,000 to the house and \$30,000 to its contents . . .

A research team from the U of California at San Diego audited medical records of 52 married couples to determine the doctors' responses to five common medical complaints: back pain, headache, dizziness, chest pain and fatigue and measured the extent and content of the physician's workup. They discovered that the only variable that correlated with the extent of workup was the sex of the patient. Men received a more extensive workup than women for all complaints studied, especially with low back pain and headache. The authors concluded that West Coast male doctors are sexist in their response to medical complaints from patients.



**The HMA Nominating Committee** met twice to receive nominations for officers and other elected positions of the Hawaii Medical Association that are to be elected by the HMA House of Delegates at its Annual Meeting October 8-12, 1979. The Nominating Committee will submit to the HMA House of Delegates the following slate of nominees:

President-Elect (1980) . . . Neal E. Winn, M.D.  
Secretary (1980) . . . . Kwong Yen Lum, M.D.  
Treasurer (1981) . . . William H. Hindle, M.D.  
AMA Delegate (1981) . . Herbert Y. H. Chinn  
Councillor from Hawaii (1981) Arch T. Wigle, M.D.

Councillor from Maui (1981) Denis J. Fu, M.D.  
Councillors from Honolulu (1981) Albert C. K. Chun-Hoon, M.D.

(Four to be elected)

Alan B. Hawk, M.D.  
James Lumeng, M.D.  
Andrew L. Morgan, M.D.  
Young K. Paik, M.D.  
Myron E. Shirasu, M.D.  
Paul Y. Tamura, M.D.

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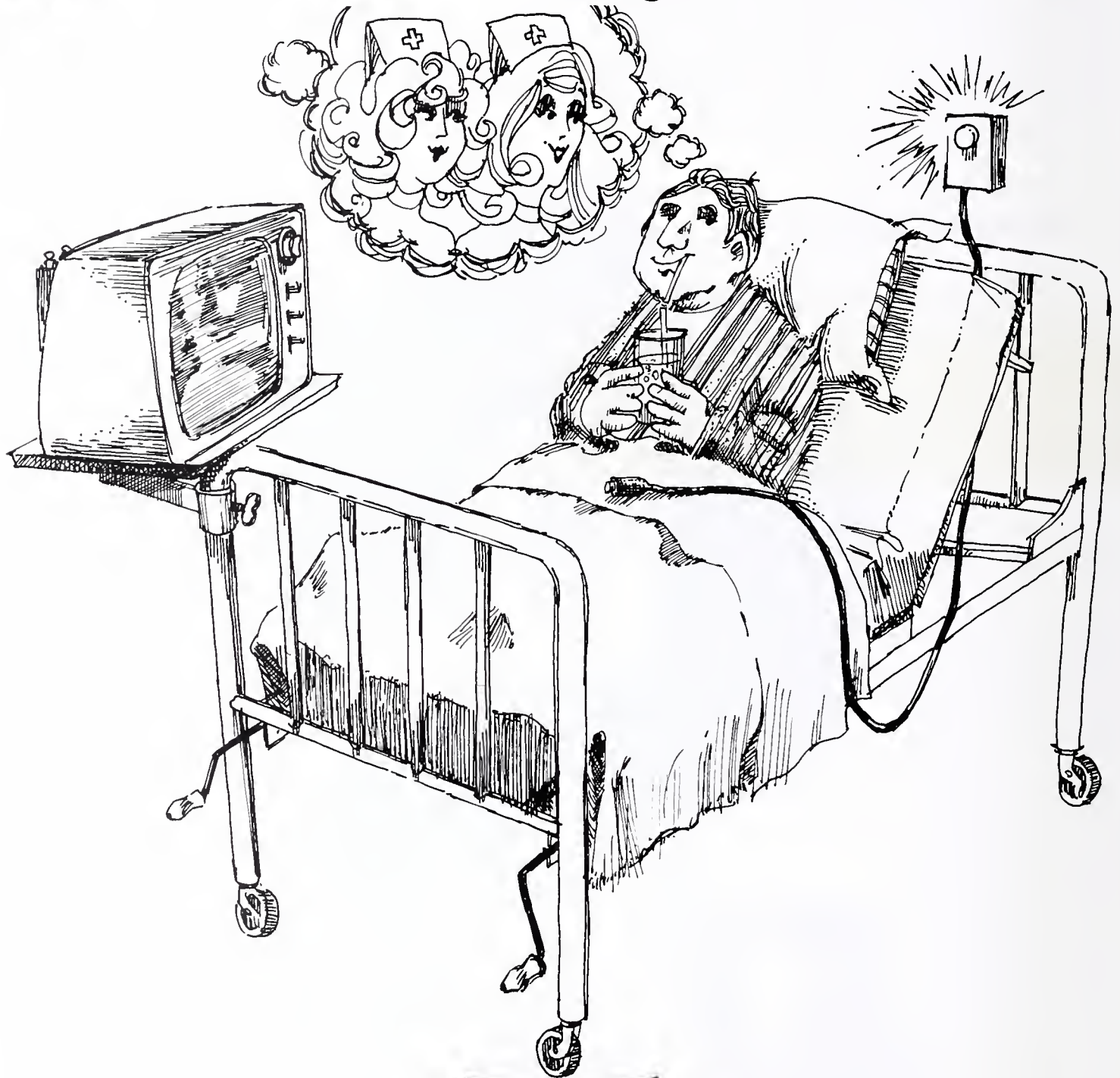
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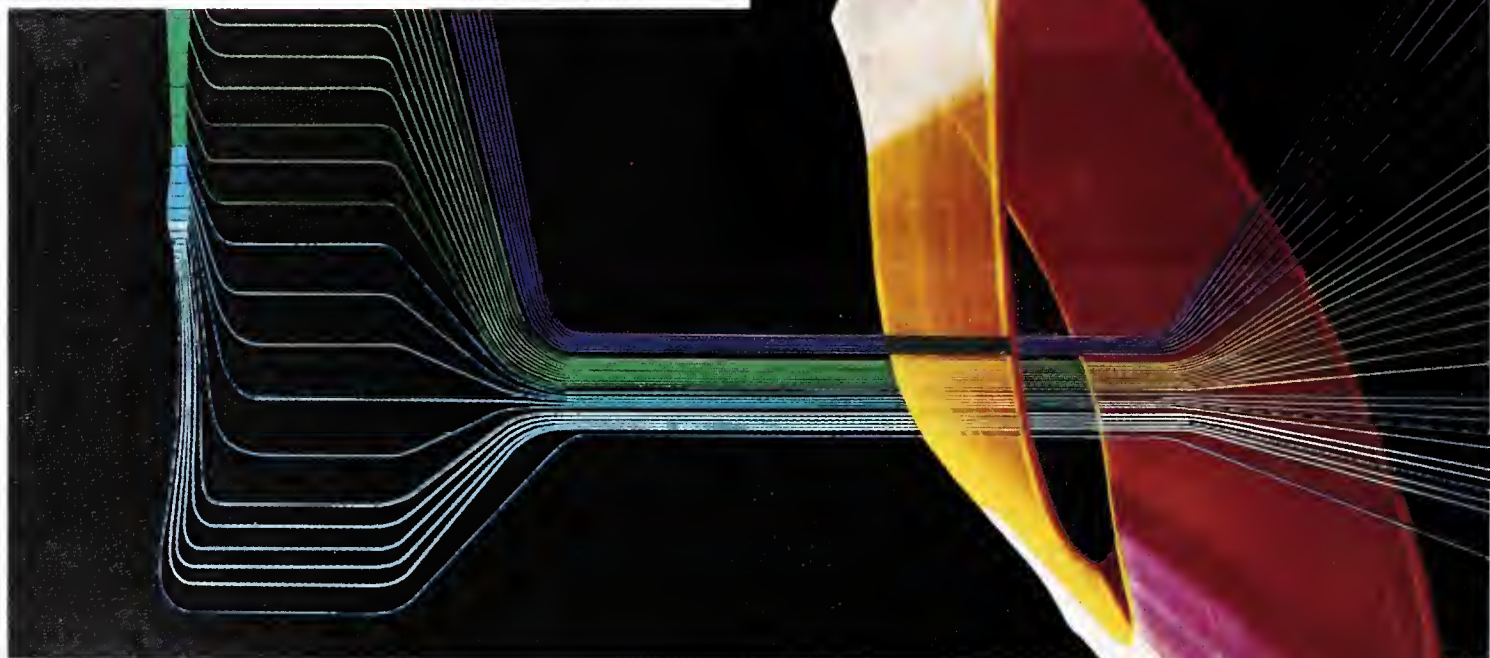
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**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants

may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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# The Maker

## Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally “expensive” and generic versions are relatively “cheap.” To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



*MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.*

**FACT:** The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

*MYTH: Industry favors only “expensive” brand names and denigrates all generics.*

**FACT:** PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



# Matters.

**MYTH:** Generic options almost always exist.

**FACT:** About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for every 45 percent of such expenditure, is a generic prescribing option available.

**MYTH:** Generic prescriptions are filled with expensive generics, thus costing consumers large sums of money.

**FACT:** Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from the same source, in the best interests of patients. In most cases the patient receives the same proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

**MYTH:** Drugs account for a major portion of the rise in health care costs.

**FACT:** Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

**MYTH:** Government intrusions into the marketplace will save tax money.

**FACT:** Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

## The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

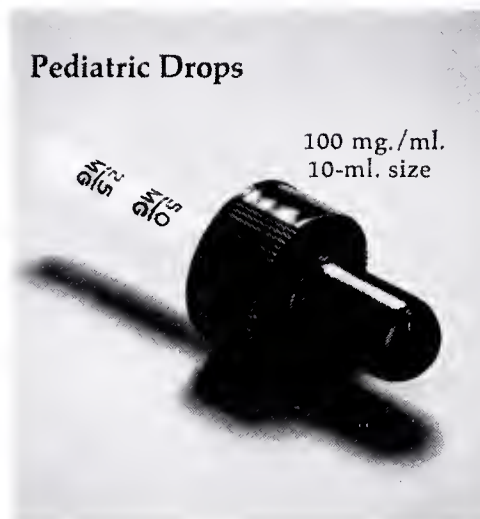
## The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

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*Limitations are encountered in  
getting data on older children*

# Limitations Encountered in a Pilot Study of Preschool Children Hospitalized For Abuse and Neglect in Hawaii, 1970-1974

GEORGE W. STARBUCK, M.D., SUSAN T. ADELSON, M.S.W.,  
and MOLLIE M. HUSTACE, B.S.N., M.P.H., Honolulu

● *A group of 35 abused and neglected children who had been hospitalized were compared with a control group of 34 children who had been hospitalized for accidental injuries. No correlation was found between high-risk factors in the prenatal and neonatal histories of the children and their later non-accidental injury. More control children were found to have new fractures only, whereas abused children had both old and new fractures, with some evidence that the old fractures had been untreated. All controls were discharged from the hospital to their natural homes, whereas 51.4% of the abused children were discharged to foster homes. Disruptions inherent in one or more foster placements may contribute to psychological and physical sequelae. More complete child developmental screening and social assessment should be made during hospitalizations and at well-child examinations to provide an optimal baseline profile of children prior to possible trauma and to provide data to be used toward effective follow-up therapy. Attention is drawn to a number of areas in this study not specifically identified in previous publications, and are the basis of some dilemmas in this field.*

Few articles using controls studied in depth are found in child abuse (non-accidental injury-NAI) literature. NAI and NAI with neglect of children occurs in a context of extreme emotion and distorted interpersonal relationships. For this reason, previous investigators have assumed that the effects on the subsequent growth and development of these children are far more profound than are those of accidental injury alone. Few follow-up studies have documented the long range effects of NAI on a

child's maturation, but estimates differ regarding the amount and degree of the physical, intellectual, and emotional sequelae of NAI.

In 1967, Elmer and Gregg<sup>1</sup> identified physical defects in 33.3% of NAI children previously hospitalized for multiple bone injuries. Of these children, 50% scored below 80 on intelligence tests, 40% exhibited some degree of emotional disturbance, and 45% had begun to speak at a later-than-average age. In all, 90% displayed abnormal development in at least one area.

In later studies by Elmer<sup>2,3</sup> of infant accidents, children under 13 months of age seen in hospital emergency rooms for injuries had been subjected to abusive incidents in 25% of the cases. In follow-up studies of this same population at ages 8 and 9 years, control cases from the same socioeconomic group, though not studied in depth, were found to have as many and as serious behavioral and learning problems as the accident or abused groups.

A third study by Martin (1972)<sup>4</sup> reported 33% of the NAI children showed mental retardation, 38% language delay, and 43% adverse neurological sequelae. Morse *et al.* (1970),<sup>5</sup> following up a group of abused or grossly neglected children, found that 42.9% were mentally retarded and 28.6% were emotionally disturbed. McRae (1973)<sup>6</sup> reported somewhat lower prevalence figures of 35.3% for intellectual retardation and 8.8% for emotional disturbance.

The variations among the figures may be due to differences in study populations and methodology. It is difficult for one to conclude from these studies, however, that the prevalence of sequelae reported for NAI children differs from that which might be found among children with other high-risk factors such as low socioeconomic status, a history of perinatal complications, or accidental injury.

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We utilized a comparison group of accidentally injured children, seeking to distinguish significant differences among measurable sequelae between NAI children and those who had suffered accidental injuries. Our objectives were (1) to describe the nature and extent of physical, intellectual, and emotional handicaps in a group of NAI children who had been hospitalized with NAI and neglect, and (2) to determine the types of follow-up health, educational, and social services utilized by these children and their families.

## Methods

In Hawaii, the State Department of Social Services and Housing (DSSH) Protective Services Unit is mandated to receive and follow through on reports of abuse or neglect. An average of 1,067 children were reported each year from 1970 through 1974, and 48.8% (521 per year) were confirmed as NAI. Approximately 3.5% of reported cases had to be hospitalized.

Our cases selected as NAI were hospitalized between January 1, 1970 and December 31, 1974, allowing a minimum of 2 years for follow-up and time to accumulate enough cases. There were 174 cases, but 100 were dropped due to a lack of confirmation of NAI or neglect or because baseline and follow-up records were inaccessible.

Three criteria were applied to the remaining 74 cases: 1. NAI or neglect had to be confirmed by the caseworker to ensure separateness of the NAI group from the accidentally injured group. 2. The children had to have been 4 years of age or younger when hospitalized, because use of school records of older children was refused by the Department of Education (DOE) without individual parental consent. 3. All children studied had to have been born on the island of Oahu so their birth histories would be available for confirmation of handicapping conditions during the neonatal period.

A comparison group of children hospitalized for accidental injuries, i.e., injuries not resulting from NAI or neglect, was selected. Controls were matched for sex, hospital diagnosis, and socioeconomic status as indicated by the use of Medicaid (DSSH) or private insurance as payment for hospitalization. Attempts to select controls for the neglect cases were unsuccessful, because findings of failure to thrive due to maternal deprivation are difficult to distinguish from the findings in cases that fail to thrive due to organic causes. In spite of this limitation, 35 cases of NAI or NAI-and-neglect and 35 controls were identified. One of the controls was later dropped when data revealed his injuries may have been due to NAI rather than to accident.

To assess the developmental sequelae of NAI and neglect and to identify pre-existing abnormalities, data were gathered on the child's health and developmental status before, during, and

after hospitalization. These data were collected from birth certificates, birth records, and the hospital records of the acute episodes which had led to a diagnosis of NAI or neglect. Follow-up data were obtained from the records of the Department of Health (DOH), DSSH, and 17 private, health-related agencies. The mean number of follow-up months was 31.

## Results

**Population.** The final matched sample consisted of 20 boys (57.1%) and 15 girls (42.9%) in each group. The sample reflected a range of ethnic groups, with a predominance of children of the following ancestry: Hawaiian/Part Hawaiian—27 children (39.1%), Mixed—19 (27.5%), and Filipino—10 (14.5%). No statistically significant difference in ethnic composition was found between the NAI and control groups. "Mixed" refers to a combination of three or more ethnic groups other than "Part-Hawaiian," e.g., Japanese-Filipino-Caucasian.

Injuries in the groups hospitalized included fractures (long bone, skull, multiple)—34 children (49.3%), skin trauma (subdural hematoma, subarachnoid hemorrhage, concussion)—15 (21.7%) and other conditions such as seizure disorder, failure to thrive or retardation—17 (24.6%). Although both groups were matched on primary diagnosis, the NAI group had more diagnoses per case (2.1 per NAI child versus 1.3 per accidentally injured child).

Once the children were matched according to sex and primary diagnosis, matching according to exact age was impossible. Pairs of NAI and AI (accidental injury) children were selected whose ages were within a year of each other. The age distribution of the children in the NAI and control groups was: 16 NAI and 3 controls (23.2% and 4.3% respectively) 6 months or younger; 5 NAI and 5 controls (7.2%) between 7 months and 1 year; 7 NAI and 14 controls (10.1% and 30.3%) between 13 months and 2 years; 4 NAI and 7 controls (5.8% and 10.1%) between 25 months and 3 years, and 3 NAI and 5 controls (4.3% and 7.2%) between 37 months and 4 years. That the majority of our NAI cases fell in younger age groups agrees with the findings of other researchers.<sup>1,9</sup> In the present study, the mean age at hospitalization for NAI was 13 months and for accidental injury, 22 months. However, the median age of our NAI group was 4 months; that of the control group was 21 months.

**Birth Records.** An even greater number of high-risk factors (prenatal examinations and month started, prenatal and delivery complications, Apgar score, time of first breath, number of neonatal complications and abnormalities) were present in the controls than in the NAI children.

In order to obtain indices of prematurity, we reviewed birth weights and gestational ages and



TABLE 1.—Birth Weights of NAI and Accidentally Injured Children

RANGE (g)	NUMBER OF	PERCENT	NUMBER	PERCENT	TOTAL	PERCENT
	NAI	OF TOTAL	OF	OF TOTAL		OF TOTAL
	CHILDREN	GROUP	CONTROLS	GROUP		GROUP
2500	2	2.9	4	5.8	6	8.7
2501-3000	10	14.5	9	13.0	19	27.5
3001-3500	7	10.1	11	15.9	18	26.1
3501-4000	10	14.5	8	11.6	18	26.1
4001-4501	6	8.7	2	2.9	8	11.6
Total	35	50.7	34	49.3	69	100.0

found them to be within the expected normal ranges for both groups of children. Of the NAI children, 12 (34%) were between 36 and 39 weeks of gestation; of the controls, 23 (65.7%) were between 40 and 44 weeks. Two (5.7%) of the NAI children had low birth weights, 2275 grams and 2041 grams ("low birth weight" being less than 2500 g). Among the controls, 4 (11.8%) were born from 32 to 35 weeks of age, and 1 (2.9%) under 31 weeks of age. Four (11.8%) weighed less than 2500 g at birth (2438 g, 2197 g, 1361 g).

Although Klein *et al* (1971)<sup>10</sup> indicated a greater risk to the low-birth-weight neonate of later child abuse than to the neonate of normal weight, no significant difference was found in the distribution of birth weights between the two groups of children in our study (Table 1) ( $\chi^2=3.211$ , d.f.=4,  $P=0.5232$ ; Fisher's Exact Test,  $P=0.34$ ). Two (5.7%) of the 35 NAI children had been low birth weight infants. This is a lower figure than the 1 infant out of 13 (7.7%) one would expect to find in the general population.

An analysis of the data revealed no significant association between ethnicity and any particular range of birth weights. A discrimination analysis from information in the birth record revealed that inclusion either in the NAI or the control group could not be predicted from the prenatal history more than  $\frac{1}{3}$  of the time.

**Medical Evaluations.** Analysis of the hospital data revealed two significant findings: First, there was a significant difference in the results of the x-rays of the two groups. The authors found that more controls—17 or 24.6% (as compared to 11 or 15.9%) had new fractures only, whereas more NAI children—5 or 7.2% (as compared to 0 controls) had both old and new fractures ( $\chi^2=9.54$ , d.f.=4,  $P=0.0489$ ). Conclusive evidence that the old fractures of the NAI children had been medically untreated is lacking. This was the first hospital admission for most of the children, and the records contained no information concerning prior treatment of a fracture.

The second significant finding involved the disposition of the cases upon discharge from the hospital. All controls were discharged to their natural homes, whereas 18 (51.4%) of the NAI children were discharged to foster homes and 1 (2.8%) to an intermediate care facility. Two (5.7%) of the NAI children died in the hospital

( $\chi^2=23.134$ , d.f.=4,  $P=0.0001$ ).

No significant differences were found between the two groups of children with respect to subsequent hospital admissions; however, 7 (20%) of the NAI infants had multiple hospitalizations during the follow-up period of the study. Five of the NAI children were admitted 2 times; 1 was admitted 3 times; and 1, 4 times. Three of the children were admitted for repeated NAI or neglect and 4 for treatment of the sequelae of their original injuries.

**Sequelae and Service Utilization.** Follow-up information on the two groups of children was obtained from medical diagnoses and specific test scores reported in the records of DOH, DSSH, and private agencies. Seven (20%) of the 35 NAI children were lost to follow-up; no contact with the participating agencies could be found. Of the 28 (80%) children with known follow-up status, 2 (7.1%) died during hospitalization for NAI and 16 (57.1%) were identified definitely as having at least one condition constituting a serious handicap. Ten (35.7%) were apparently functioning at a normal developmental level and seeking well-child care or general counseling services.

Table 2 represents the prevalence of each medical diagnosis or type of developmental delay found among the 16 NAI children. Several of the cases had multiple and severe handicapping conditions; the total prevalence of conditions was 1.4 times the number of children. Nine of the 16 had at least one physical abnormality. Four of the 9 children with medical diagnoses of handicap(s) had IQ or DQ test scores lower than 80; 2 had scores in the 80s; and 2 scored between 100 and 110. Denver Developmental Screening Test (DDST) scores revealed developmental delays in 7 of the NAI cases. The diagnoses of emotional disturbance in 4 of the children included "exacerbated adjustment reaction of childhood," "severe acting out behavior," and "enuresis."

In the control group, 13 (38.2%) were found to have had agency contacts subsequent to hospital admission for accidental injuries. Figures for both mean number of agency contacts and hours of services were lower than those found for the NAI group. Of the 13, 3 were identified as having a handicapping condition; 2 were developmentally delayed; one had an IQ score of 62 and subnormal language test score; the sec-

TABLE 2.—Handicapping Conditions Found Among NAI and Accidentally Injured Children

	NUMBER IN NAI GROUP	PERCENT OF TOTAL GROUP	NUMBER OF CONTROLS	PERCENT OF TOTAL GROUP	TOTAL	PERCENT OF TOTAL GROUP
Number of Children With One or More Handicapping Conditions	16	23.2	3	4.3	19	27.5
Number of Children With One or More Physical Disorders	9	13.0	3	4.3	12	17.4
Types of Physical Disorders:*						
Seizures	4		0		4	
Paresis	4		0		4	
Paraplegia	2		0		2	
Cerebral Palsy	2		1		3	
Cardiovascular Abnormality	3		0		3	
Vision Impairment	3		2		5	
Hearing Impairment	3		0		3	
Microcephaly	1		0		1	
Growth Retardation	1		0		1	
Scars	1		1		2	
Number of Children With Some Degree of Developmental Delay	9	13.0	1	1.4	10	14.5
Type or Degree of Delay:*						
Retardation						
(IQ Score less than 80)	6		0		6	
Developmental Delays						
(Denver Developmental Screening Test Results)	7		1		8	
Speech/Language Delay	9		0		9	
Number of Emotionally Disturbed Children	4	5.8	0	—	4	5.8

\*Duplicated count

ond showed spasticity; and the third child had extensive burn scars.

Department of Social Services and Housing. Since none of the controls received social services from DSSH, no comparisons could be made between the NAI children and the controls. However, the data on the NAI children revealed two findings of note. Of the 35 NAI children, 18 were placed in foster care. Five (7.5%) had only 1 foster placement; 5 (7.5%) had 2 placements; 4 (6.0%) had 3 placements; and 2 (3.0%) had 4 placements. Five (7.5%) children were placed from 1 to 15 months; 6 (9.0%) from 16 to 30 months; 2 (3.0%) from 31 to 45 months; and 3 (4.5%) over 45 months. Foster care placement is utilized extensively by the DSSH Protective Services Unit. Although foster placement may provide physical safety (though not necessarily), the effects of repeated and lengthy family disruptions on the NAI children and on their families are unknown.

Department of Health and Private Agencies. Data concerning the special services received by the NAI children after hospitalization produced

some interesting results. Among the services received (orthopedic, cardiovascular, neurological, and others), there was a significant difference between the 2 groups in the utilization of child mental health services. In the NAI group, 6 children received from 1 to 10 counseling sessions, whereas none of the control children received any mental health services (Table 3A) ( $\chi^2=15.946$ , d.f.=8,  $P=0.0432$ ). The parents of 14 (38.9%) of the NAI children attended from 1 to more than 90 sessions, with 7 (50%) attending from 1 to 10 sessions (Table 3B). The mean number of hours spent both by the children and by the parents in post-hospitalization mental health counseling was also significant. A mean number of 1.11 hours was spent with the parent(s) (child psychotherapy:  $t=2.03$ , d.f.=41.52, 2-tailed  $P=0.049$ ).

Recalling that the groups had been matched on socioeconomic status, it was noted that the NAI group used significantly more well-baby clinic and other public health nursing services than did the controls ( $t=-2.01$ , d.f.=34.0, 2-tailed  $P=0.049$ ). The foster placement of many

TABLE 3A.—Utilization of Child Mental Health Services by NAI and Accidentally Injured Children

	NUMBER OF NAI CHILDREN	PERCENT OF TOTAL GROUP	NUMBER OF CONTROLS	PERCENT OF TOTAL GROUP	TOTAL	PERCENT OF TOTAL GROUP
NUMBER OF SESSIONS						
0	28	49.6	34	49.3	62	89.9
1-10	6	8.7	0	—	6	8.7
11-20	1	1.4	0	—	1	1.4
Total	35	50.7	34	49.3	69	100.0



TABLE 3B.—Utilization of Mental Health Services by Parents of NAI and Accidentally Injured Children

NUMBER OF SESSIONS	NUMBER OF NAI CHILDREN	PERCENT OF TOTAL GROUP	NUMBER OF CONTROLS	PERCENT OF TOTAL GROUP	TOTAL	PERCENT OF TOTAL GROUP
0	22	31.9	33	47.8	55	79.7
1-10	7	10.1	0	0.0	7	10.1
11-20	1	1.4	0	0.0	1	1.4
21-30	2	2.9	0	0.0	2	2.9
31-40	0	0.0	1	1.4	1	1.4
41-50	0	0.0	0	0.0	1	0.0
51-60	1	1.4	0	0.0	1	1.4
61-70	1	1.4	0	0.0	1	1.4
90	1	1.4	0	0.0	1	1.4
Total	35	50.7	34	49.3	69	100.0

of the NAI children, together with their increased need for follow-up, may have accounted for this utilization pattern.

The two groups of children showed some differences in numbers of agencies used before hospitalization but the most significant finding (Table 4) appeared after their hospitalization, when the NAI children utilized almost 10 times more services than did their matched controls. The most significant difference was in the amount of children's mental health services used by the two groups. This finding indicates that, even though the injuries were comparable between the two groups of children, it was the source of the injury—whether accidental or inflicted—that determined whether or not a child would later receive psychotherapy.

### Discussion

Since a definite matrix of prenatal and neonatal events may not be identified as a predictor of potential NAI, a closer developmental screening and social assessment of all children is necessary for identification of (early) developmental delays and identification of possible NAI. Only 4 of the sample children (of the 15 given the DDST during follow-up) had received this test before being hospitalized; adequate social assessment was even more limited.

Children of Hawaiian-part Hawaiian extraction predominated in the final matched sample, with no significant ethnic differences between NAI and controls. The skeletal fractures lead the list of injuries and the NAI had more bone injuries per child than the accident or control

group. Controls had more new fractures, while NAI had both old and new skeletal injuries. It was unexpected to find that the high risk factors in the prenatal and neonatal records were greater in the controls; the incidence of prematurity were in the normal range for both groups. There was no significant association between ethnicity and any particular range of birth weights. Prediction of the incident of injury in NAI or control groups was not possible more than 1/3 of the time through a discrimination analysis.

All controls were discharged home. Of the NAI cases, 18 (51.4%) went to foster homes; the effects of foster home placement on the child were a source of concern as a sequela of child abuse, since this is such a drastic environmental change, also, its effects are difficult to separate from the psycho-emotional effects of the abusive incident.

Of the 28 (80%) with a known follow-up status, 16 (57.1%) of the NAI had at least one serious handicap and 10 (35%) were functioning at a normal level. Of the controls, 13 (38.2%) had agency contact before injury.

The children in the NAI group used more well baby clinic visits and other public services. Agencies used were 10 times more in the non-accidental injury group, the greatest use of services being in mental health. Psychiatric and psychological consultations are of great importance, in both diagnostic and therapeutic services; with documentation, the NAI child is insured of a more appropriate follow-up program.

Some areas in this study were compared to findings by other investigators for similarities

TABLE 4.—Agency Utilization by NAI and Accidentally Injured Children

	NAI GROUP	ACCIDENTALLY INJURED GROUP	<u>t</u> VALUE	d.f.	2-TAILED PROBABILITY
Average Number of Agencies Used by Child Before Being Hospitalized	.66	.38	-1.31	50	0.197
Average Number of Agencies Used by Child After Being Hospitalized	1.11	.13	-4.13	41	0.000
Average Number of Hours Spent by Child In Mental Health Services After Being Hospitalized	1.11	0	-2.28	34	0.029

and differences. It was confirmed that hospitalized NAI cases were in the younger age group. Other authors did not carry out an in-depth study to show their controls were free of variables, which is the same flaw we had in this study. Contrary to Klein<sup>10</sup> and others, we found that the low birth weight neonate was not high risk for abuse and neglect in Hawaii; in fact, the incidence was actually less than 1 infant out of 13 (7.7%) which one expects to find in the general population. It was also learned that most investigators combine NAI and neglect into a single group in making up the "abused" cases.

### Limitations

Limitations were encountered in obtaining a sample of NAI or NAI-and-neglected children that would better fulfill the objectives of the study. Comprehensive data were needed on each case; consequently, a younger group of children who had been born on Oahu were selected. The need to obtain matched controls further restricted the sample. Thus, although an experimental design was utilized in the final analysis, the sample size was not large enough to reveal significant findings concerning clinical data or specific test scores. The Department of Education refused our request for record review without parental consent, thereby limiting our study group even further to the age group of 4 or less.

Being forced to comply with informed or parental consent, with its increasingly stricter and more detailed interpretation and enforcement, may seriously limit the number of cases for future study samples. We are already dealing with frightened, anxious, defensive people who have been restricting their responses to our questions from the beginning, and the validity of their responses is difficult if not impossible to confirm. In selection of a sample, the more variables one uses, the greater the case loss.

In-depth study of accidental injury requires consent, money and manpower in designing future research in this field. A medical record, which should be the single home containing all the child's medical information, needs to contain better documentation relative to psychosocial problems as well as behavioral and development assessment which are statistically hard to analyze.

The present study reveals a suggestive lack of difference between the perinatal histories of the NAI children and those of the accidentally injured children. The exploration of frequencies of certain early indicators of risk in the birth record failed to show that NAI children began as high risk neonates.

The study repeatedly identified problem areas, raising more questions than it answered. Funds did not allow for a broader study. No identical studies carried out in different geographical locations were available for compari-

sons. Answers to some of the study's questions are not to be found in any publication.

Additional prospective studies should address, but not be limited to, the following questions: In the under-2500 g group, is there a level where the risk of NAI is greatest? Is the high-risk infant more vulnerable to neglect than to NAI? Should the low-birth-rate groups be divided into separate NAI and neglect groups? Is there a difference in incidence of NAI/neglect in the low-birth-weight child and the child of low birth weight for gestational age? Is there an actual difference in maternal-infant dysfunction as manifested by neglect or by the failure-to-thrive syndrome, when one compares the low-birth-weight infant under 1500 g with a group between 1500 and 2500 g? (Minde<sup>11</sup> states that infants under 1500 g or 29 weeks' gestation do not respond to stimulation.) If stimulation in infants under 1500 g does not cause a response, and lack of parental stimulation and nurturing is a high risk factor in cases of NAI and neglect, can important new information be identified in this group? Would family therapy be more effective than individual therapy since NAI/neglect is a family problem? Inasmuch as NAI/neglect predictors are weak, shouldn't a study of high risk families who do *not* abuse or neglect be undertaken? If disruption inherent in foster placement is one major sequela of NAI, how best can such disruption be decreased? Would the findings in a study of non-hospitalized NAI/neglect children differ from those in this study? Is there a need to determine the true incidence of NAI and multiple skeletal injury in the population which does not come to the pediatric setting, or in that population which is seen but is not adequately studied from a radiological or behavioral standpoint?

### Summary

The low-birth-weight neonate in Hawaii was not high risk for NAI and neglect in this study. Early indicators for risk in birth records failed to support that NAI children began as high risk neonates. A larger number of cases needs to be studied. Sequelae of foster care placement should be evaluated in depth. Need for informed consent in similar studies will tend to limit the kind of investigation undertaken. Better documentation of psychosocial problems as well as behavior and development assessments in records is imperative. Hospitalized NAI cases were in a younger age group. Other authors were found not to have studied controls in depth for possible abuse. Controls had new fractures only while non-accidentally injured children had more old and new fractures.

No proven conclusions are presented, but problems and limitations in the field of nonaccidental injury and neglect not specifically iden-



tified in previous publications are brought into clearer focus. Future studies should direct their attention to these troublesome areas, particularly since so many reports being published appear repetitious and are no longer as helpful in this field as one would like.

From this pilot study, it is felt that there are 5 areas urgently in need of study: 1) Low birth weight as high risk for abuse and neglect; 2) The characteristics of the high risk non-abusive par-

ent; 3) Separate studies of abuse and of neglect, no longer pooling them into a single category; 4) The low-birth-weight neonate, not hospitalized, as possible high risk for NAI/neglect; 5) Controls should be used in more studies. Studies should include in-depth analysis of controls to show they are actually controls, assuring that a reasonable attempt was made to determine that the comparison group was free of the variables being studied.

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# Nephrolithotomies at Kaiser Medical Center

## Review and Results

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● *Parenchymal renal surgery for calculus disease at Kaiser Medical Center, Honolulu, is reviewed and one unusual case is presented. We suggest that most staghorn calculi can be managed more easily by the safer in situ approach rather than by benchsurgery.*

### Material and Methods

From April, 1975, until July, 1978, 57 surgical procedures were carried out on kidneys for stone disease at Kaiser Medical Center. The procedures were as seen in Table 1.

TABLE 1.—Renal stone surgery at KMC 4/75 - 7/78

pyelolithotomies	43	
pyelonephrolithotomies	5	
anatomic nephrotomies	4	12
segmental nephrectomies	3	
nephrectomies	2	
Total	57	

This paper concentrates on 12 operations involving the renal parenchyma: pyelonephrolithotomies, anatomic nephrotomies and segmental nephrectomies.

Modern techniques make it possible to:

1. remove all calculi with only minimal renal parenchymal damage,
2. repair obstructed calyces,
3. clear urinary tract infection and
4. prevent the recurrence of stones.

The risk of complication in nephrolithotomies is lessened if a thorough preoperative evaluation is carried out. We screen our patients for endocrinologic, malignant, degenerative or other medical diseases associated with recurrent renal calculi.

Several preoperative urine cultures with sensitivity studies are carried out. IV-antibiotic treatment is begun 24 - 48 hours prior to surgery.

Roentgenological studies preoperatively include IVP, nephrotomograms, retrograde

pyelograms. If there is evidence of renal anomaly or extremely large staghorn calculi, renal arteriography is carried out.

Approximately 20% of the cardiac output perfuses the renal circulation. Special emphasis is therefore placed on renal blood supply—first described by Max Brödel<sup>1</sup> in the Johns Hopkins Hospital bulletin in 1901—with the identification of the posterior segment of the renal artery prior to the nephrotomy incision.

Briefly, the procedure is as follows: mobilization of the kidney through a flank incision, control of the arterial blood supply, cooling of the kidney with isotonic saline applied at 7° C as a bath, capsular and parenchymal incision parallel to the lateral border of the kidney through a relative avascular area, entering the renal pelvis and after the removal of the calculus and thorough inspection of the renal pelvis, closure in layers.

If a renal segment is severely diseased by a staghorn calculus, a segmental nephrectomy is carried out. The line of incision is parallel to the margin of the segment and encompasses the entire affected segment.

### Results

Though the number of patients is small, the results concur with larger series. Six patients presented with pain, 5 with acute or chronic UTI and 1 patient with a 15-year history of recurrent renal calculi. There were 5 Filipino patients and 7 of various racial backgrounds.

In no patient was there any abnormality of serum calcium, phosphorus and uric acid levels. The organisms found in urines of our patients were *Proteus mirabilis* in 4, *Klebsiella* in 1, *E. coli* in 1 and multiple organisms in 1. There was no growth in 3. This concurs with larger statistics, where the urea splitter, *P. mirabilis*, leads in frequency.

Five of 12 patients received transfusions during or after the surgical procedure. Blood-



pressures were unchanged in 11 patients, 1 became normotensive.

The stone removal was complete in 9, incomplete in 3 patients (21 complete, 7 incomplete—Medical University of South Carolina<sup>2</sup>). One patient had new stone formation.

The average hospital stay for each patient was 11.3 days postoperatively, which compares well with the 10.7 of the "stone center" Bowman Gray School of Medicine, North Carolina<sup>3</sup>.

### Case report

The most challenging operation was performed on a 45-year-old Filipino woman (C.B. 160958), who was found to have persistent pyuria and microhematuria, in spite of antibiotic therapy after her initial visit in September, 1975.

She had no other symptoms, specifically no pains. Her past urological history was negative. She had a 10-year history of diabetes mellitus, but she admitted she did not follow her diabetic diet closely nor take her medications regularly. Urine cultures revealed enterococci. The initial KUB of October, 1975 (Figure 1) does not differ much from the 2 hr pyelogram, showing a large right staghorn calculus, a left lower pole renal and a left ureteral calculus, poor right renal function, and only minimal function in the much smaller left kidney.

In October, 1975, she underwent a left ureterolithotomy; however, function of the left kidney did not improve.

In March, 1976, the patient was readmitted for surgical management of the growing right staghorn calculus. She still had no pains, the urine remained infected in spite of continuous antimicrobial therapy. Repeated serum calcium, phosphorus and uric acid levels were normal. There was no sign of hyperparathyroidism. BUN and creatinine remained elevated, but stable at 25 mg % and 2.1 mg % respectively. The 24-hr urinary excretion for calcium, phosphorus and uric acid were normal. The creatinine clearance was surprisingly good, with 70 ml/min (normal 75 - 105 ml/min).

The removal of the calculus was not performed, because of the still stable renal function, the patient's relative well being and the high risk of losing the right kidney and dependence on renal dialysis.

Follow-up films revealed continuous growth of the staghorn calculus, with thinning of the renal parenchyma. The arteriogram of August, 1977 (Figure 2), shows the large staghorn calculus and a normal renal arterial blood supply. Renal function had deteriorated; the patient became azotemic with a BUN of 25 mg % and a creatinine of 4.1 mg %.

With the growth of the calculus, the loss of renal parenchyma and the onset of azotemia, the survival of the right kidney was limited. The patient would soon need renal dialysis unless the calculus was successfully removed.

The patient accepted the surgical risk and was taken to the operating room. The kidney was

FIG. 1—KUB 10-75. Right staghorn calculus, Left renal and ureteral calculi.



FIG. 2—Preoperative right renal arteriogram: Staghorn calculus, Normal renal arteriogram.



approached through a right flank incision; much fibrosis was encountered around the kidney, but with sharp dissection the kidney was freed in its entirety to provide access to the renal pedicle.

Cooling was provided with slush within a plastic coated sheet. After clamping the renal pedicle, a posterior capsular incision was made after the manner of Boyce and Smith<sup>4</sup>. The collecting structures were exposed and all calyces viewed in their entirety. A large volume of calculus was removed. Closure was performed in layers.

Postoperatively, the patient did well and had good urinary output. The urine was grossly bloody for the first 72 hrs. She received a total of 5 transfusions. She was discharged on the 16th postoperative day with normal vital signs, the preoperative azotemia no longer present, BUN and serum creatinine being 20 mg % and 1.9 mg %, respectively.

It took a considerable time to reassemble all 42 pieces to complete the staghorn calculus as it was positioned in the kidney (Figure 3). The stone's weight was 101 gms. It measured  $9.5 \times 7 \times 5$  cm, and was, as expected, of mixed composition: calcium, magnesium, phosphate, carbonate and ammonia.

More than one year postoperatively, the patient is well, active, with normal vital signs, a BUN

of 18 mg %, a serum creatinine of 1.8 mg %, a urinalysis with 12 WBCs and 1-2 RBCs per high power field and negative urine cultures. The postoperative pyelogram of October, 1977, shows minor remaining calculi in the parenchyma of the right lower renal pole with good renal function (Figure 4). The patient is maintained on a high fluid, low calcium diabetic diet, which she follows closely, and on ascorbic acid and methenamine hippurate.

### The role of benchsurgery

Ota<sup>5</sup> in 1964 combined renal autotransplantation with *ex-vivo* renal parenchymal surgery, which is now referred to as benchsurgery. Originally only applied to renovascular lesions, indications for benchsurgery have been expanded to include ureteral injury, malignancies in solitary kidneys, massive renal trauma, and occasionally staghorn calculus in a solitary kidney with other diseases such as ureteropelvic disproportion or renal artery stenosis. The procedure requires considerable technical mastery by a well trained and maintained surgical team.

We feel that the number of patients at Kaiser Medical Center and probably even in the State of Hawaii does not justify such a rare and costly procedure. Most renal lesions can be managed more easily by the safer *in situ* approach.

FIG. 3—Reassembled staghorn calculus.



FIG. 4—Postoperative IVP 10/77: Minor residual calculi in lower pole of right kidney.

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# Ventricular Septal Rupture Complicating Acute Myocardial Infarction: An Indication for Early Intervention

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● *Four patients had ventricular septal rupture complicating acute myocardial infarction and underwent surgical repair. Long-term survival was achieved in 3 patients, 2 of whom were operated within 2 weeks after the original infarct. Contrary to widely held beliefs, early cardiac catheterization and surgery are not only safe, but preferable to unnecessary delay.*

Rupture of the ventricular septum is one of the most catastrophic complications of acute myocardial infarction. Although it is a rare event, accounting for only 1-2% of deaths in acute myocardial infarction,<sup>1</sup> a prompt, precise diagnosis of this entity is very important, because surgical treatment can be most rewarding.

Since the first report of the surgical treatment of post-infarction ventricular septal defect (VSD) in 1957,<sup>2</sup> there have been many case reports and excellent reviews published.<sup>3,4,5,6,7</sup> We report here our experience with this clinical entity in one hospital during the last 3 years. Four patients were encountered. (Table 1)

## Case Reports

Case 1. A 56-year-old woman was admitted to Straub Hospital on October 12, 1976, after the sudden onset of chest pain, dyspnea, diaphoresis and nausea. Physical examination showed: blood pressure 130/86 mm Hg; pulse 56 and regular; no neck vein distension; rales in both lung bases; heart enlarged, S<sub>3</sub> present at the apex, no audible murmurs. Chest x-ray showed cardiomegaly and

moderate pulmonary congestion. EKG showed an acute anteroseptal myocardial infarction. CK was elevated to 915 with a positive MB band. (Normal less than 180.)

She was treated with digoxin and furosemide with improvement and her activity gradually increased.

Six days after admission, she suddenly became confused and her blood pressure was unobtainable. She was started on levarterenol drip and her blood pressure was maintained at 80 systolic. A new Grade 3/6 pansystolic murmur was audible at the apical area. Immediate right heart Swan-Ganz catheterization in the CCU documented 60% left-to-right shunt at the ventricular level by oxygen series. Mean pulmonary wedge pressure was 35 mm Hg. Intra-aortic balloon pump was instituted immediately and her condition was stabilized.

She underwent cardiac catheterization the next day. There was complete occlusion of the left anterior descending coronary artery within 1 cm of its origin, while the right and left circumflex arteries were free of significant stenosis. The left ventricular angiogram revealed an apical aneurysm and an apical VSD. The patient was immediately taken to the operating room and amputation of the anterior-apical myocardium incorporating closure of the VSD was successfully completed.

Her post-operative course was complicated by several episodes of ventricular tachycardia and atrial flutter with rapid ventricular rate, which required cardioversion and several months of treatment with quinidine. She is now asymptomatic and on no medication 25 months following the surgery.

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TABLE 1.—Summary of clinical data

CASE NO.	AGE, SEX	INFARCT SITE	TIME FROM INFARCT			SURGICAL PROCEDURE	SURVIVAL
			RUPTURE	INSERTION OF IABP	SURGERY		
1.	56;F	antero-septal	6 days	6 days	7 days	Amputation of anterior apical myocardium	Alive after 25 mo.
2.	65;M	inferior	3 days	not used	43 days	Repair of VSD CABG MVR	Alive after 18 mo.
3.	65;F	inferior	3 days	4 days	4 days	Repair of VSD Infarctectomy	Died 1 day post-op.
4.	67;F	antero-lateral	2 days	3 days	12 days	Repair of VSD Infarctectomy	Alive after 2 mo.

Case 2. A 65-year-old man was transferred on May 24, 1977, 15 hours after admission to another hospital for acute myocardial infarction and ventricular fibrillation which had responded to countershock. Physical examination showed: blood pressure 130/80 mm Hg; pulse 88 and regular; no neck vein distension; lungs clear; heart not enlarged, no audible murmurs or gallops; no peripheral edema. Chest x-ray was normal. EKG showed acute inferior myocardial infarction and left ventricular hypertrophy. CK was elevated to 1800.

Two days after admission, he developed moderate dyspnea, rales at both bases and a Grade 4/6 pansystolic murmur at the apex, radiating to both the left sternal border and the axilla. Chest x-ray showed cardiomegaly, bilateral pleural effusion and pulmonary congestion. EKG showed slightly elevated ST segment at lateral leads with evolving inferior myocardial infarction.

It was felt that the murmur was probably due to papillary muscle dysfunction and he was treated with digoxin and furosemide for his congestive heart failure. On the 20 day, the patient was discharged with mild residual heart failure, on continued digoxin and furosemide.

Eight days later, he was again transferred to Straub Hospital, having been readmitted elsewhere with acute pulmonary edema. Physical examination showed: blood pressure 80/50 mm Hg; jugular vein distension to the angle of the jaw; rales over the lower third of both lung fields. Cardiac examination revealed the same Grade 4/6 holosystolic murmur at the apex radiating to both the left sternal border and the axilla, and a loud third heart sound. He responded well to intravenous doses of furosemide and his heart failure improved markedly.

Cardiac catheterization 2 weeks after readmission revealed total occlusion of the right coronary artery proximally, 70% stenosis of the proximal left anterior descending artery, and 80% occlusion of the marginal branch of the left circumflex artery. The ventriculogram showed a VSD with 50% left-to-right shunt.

Two days later, repair of the VSD and coronary bypass to both the left anterior descending artery and the marginal branch of the left cir-

cumflex artery were successfully accomplished. In addition, a Bjork-Shiley mitral valve was inserted due to the involvement of the papillary muscle in the infarct and ventricular distortion following plication of the posterior wall.

In the 18 months following the surgery, he continues to do well; but, he is still receiving digoxin and diuretics.

Case 3. A 65-year-old female with obtundation, severe respiratory difficulty and cold extremities was transferred on June 10, 1978, two days after admission to another hospital for acute myocardial infarction.

She originally presented with a 2-day history of chest pain. EKG showed Q waves and ST segment elevation in leads II, III and AVF. The diagnosis of acute myocardial infarction was made. One day prior to her transfer, a new Grade 4/6 pansystolic murmur was heard. Swan-Ganz catheterization revealed a 20% step-up of oxygen saturation in the pulmonary artery, compared with the right atrium. Eight hours prior to transfer, she had become obtunded and hypotensive, requiring large doses of dopamine and levarterenol to maintain her systolic blood pressure at 80 mm Hg. She had been anuric for several hours prior to transfer.

On physical examination: Pulse 84 and regular; systolic blood pressure 60 mm Hg, palpable; respiration 48 and labored. Extensive rales were heard over the lung fields and a Grade 3/6 pansystolic murmur was noted.

She was intubated and the intra-aortic balloon pump was inserted. Three hours after the transfer, cardiac catheterization was performed with continued support from the intra-aortic balloon pump and respirator. Coronary angiography showed total occlusion of the right coronary artery within 1 cm of its origin, while the left coronary system was free of significant stenosis. Left ventriculography showed a VSD, and no mitral regurgitation. The patient developed ventricular fibrillation following the completion of cardiac catheterization. External cardiac massage was maintained while she was taken to the operating room.

Infarctectomy and repair of the VSD were accomplished. A temporary pacemaker was sutured to the anterior surface of the right ventricle



because of bradycardia. Postoperatively, she remained comatose and her cardiac output progressively declined despite the use of the intra-aortic balloon pump and pressors. She expired on the second hospital day.

**Case 4.** A 67-year-old female was admitted to Straub Hospital on August 24, 1978 with a 2 day history of recurrent chest pain. She had had mild hypertension in the past, but no history of myocardial infarction or angina.

On physical examination, she appeared acutely ill. Blood pressure was 90/60 mm Hg and pulse was 120 and regular. There was no neck vein distension and the chest was clear. Examination of the heart revealed a Grade 3/6 holosystolic blowing murmur at the left sternal border radiating to the base. There was no peripheral edema. Chest x-ray showed moderate cardiomegaly and slight pulmonary congestion. EKG revealed Q waves and ST segment elevation at  $V_1$ - $V_6$ , AVL and I, with reciprocal ST segment depression in II, III and AVF. CK was elevated to 2600 with a positive MB band.

Within 24 hours of admission, she became markedly dyspneic and developed progressive left heart failure. Swan-Ganz catheterization revealed a 52% left-to-right shunt at the ventricular level by oxygen series. Mean pulmonary wedge pressure was 24 mm Hg without giant V waves. Intra-aortic balloon pump was inserted and the patient's condition was stabilized. Her congestive heart failure persisted over the next 10 days despite the use of furosemide, digoxin and the intra-aortic balloon pump.

By 12 days after admission, cardiac catheterization revealed total occlusion of the left anterior descending artery proximally. The left ventriculogram showed apical aneurysm and apical VSD. That day, anterior infarctectomy and closure of the VSD were successfully performed.

The patient continues to do well 2 months following the surgery while still receiving digoxin and furosemide.

## Discussion

Death due to arrhythmias among patients who have had an acute myocardial infarction has been markedly reduced by the establishment of coronary care units and the use of vigorous prophylaxis and treatment.<sup>8</sup> However, the mortality following mechanical failure manifested by cardiogenic shock or pulmonary edema remains very high.<sup>8,9</sup>

By far the most common cause of hemodynamic impairment leading to cardiogenic shock is the loss of a massive amount of myocardium. Although much research has been performed over the past 10 years to find ways of limiting infarct size, there has not been any major breakthrough. The salvage rate for patients who have lost more than 40-50% of their myocardium

is extremely low. On the other hand, in a minority of patients, a mechanical derangement, ventricular septal rupture or acute mitral regurgitation, is the main cause of hemodynamic impairment, while a relatively large amount of the myocardium is preserved. It is with this group of patients that intensive medical and surgical therapy is most rewarding.

Prior to the advent of surgical management, rupture of the interventricular septum complicating acute myocardial infarction was almost invariably fatal.<sup>10</sup> Over 50% of the patients died within the first week and nearly 90% within 2 months.<sup>11</sup> Starting with the first successful surgical repair by Cooley et al.,<sup>2</sup> remarkable advances in cardiac surgery have greatly improved the prognosis for patients with postinfarction VSD.<sup>4-7,12</sup> A hospital survival rate of 66% was achieved in one large series.<sup>7</sup> Since early and emergency repair has been successfully performed in many centers,<sup>7,12,13</sup> early diagnosis is of critical importance.

Septal rupture may occur within hours to weeks following acute myocardial infarction; but, most commonly occurs within the first week, as in all of our cases. The majority of ruptures involve the lower portion of the septum, although ruptures of the posterior portion are not uncommon. (Cases 2 and 3)

Clinically, rupture of the ventricular septum is characterized by rapid deterioration, with the sudden appearance of a holosystolic murmur at the lower left sternal border, often accompanied by a thrill. However, the thrill may be absent, and in cases of posterior location of septal defects, the murmur may be heard best at the apex. Consequently, clinical differentiation of septal rupture from mitral regurgitation can be difficult.

Definitive diagnosis can be made at the bedside, using the Swan-Ganz catheter. The demonstration of a significant "step-up" of oxygen saturation at the ventricular level by drawing blood samples simultaneously from the pulmonary artery and the right atrium is diagnostic of acute septal rupture. Additional sampling from a systemic artery permits quantification of the shunt. No change in oxygen saturation is seen in cases of acute mitral regurgitation. A giant V wave in the pulmonary wedge pressure tracing suggests this diagnosis rather than VSD. In Case 2, earlier diagnosis and treatment would have been achieved, and Swan-Ganz catheterization been used.

Many authors recommend that cardiac catheterization and surgery be delayed 3 to 6 weeks after the original infarction because of the higher mortality rate of earlier intervention. However, delaying surgery for patients with severe hemodynamic impairment may result in progression of myocardial necrosis or other complications of low cardiac output. Since early operative treatment can be accomplished rela-

tively safely,<sup>12,13</sup> delay of surgery for patients who are in severe congestive heart failure or cardiogenic shock should be avoided.

The early use of the intra-aortic balloon pump can stabilize the hemodynamic status of the patient who requires emergency surgery. (Cases 1 and 4) In Case 3, the patient may have survived if this had been employed earlier and she had not been left in severe cardiogenic shock for almost 8 hours.

### Conclusion

Rupture of the ventricular septum is a highly lethal complication of acute myocardial infarction. It is, however, a treatable entity, as illustrated by this small series.

We believe that the keys to successful management are:

1. Being on the look-out for this complica-

tion in subjects with acute myocardial infarction, especially when there is rapid deterioration and a systolic murmur present.

2. Use of the Swan-Ganz catheter which monitors response to treatment and, by oximetry sampling, confirms the diagnosis.

3. Early and aggressive supportive measures as needed, including the use of the intra-aortic balloon pump.

4. Coronary and left ventricular angiography, mainly to define arteries that can be bypassed at the time of VSD closure, and areas of the free wall that may require resection.

5. Early surgical repair.

It should be emphasized that early angiography and surgery are not only safe, but preferable to unnecessary delay. When these principles are followed a successful outcome can be anticipated from this serious complication of acute myocardial infarction.

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### BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

*Lydia O'Leary*  
OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288





## Final Common Pathway

SIDS is short for Sudden Infant Death Syndrome.

At a recent seminar in Waikiki, sponsored by the University of Hawaii School of Medicine, Kapiolani- Children's Hospital and others, a multiplicity of causes of this insidious "thief in the night" was proposed. Sleep apnea; viral respiratory infections, mild in degree; hypersensitivity state, and prematurity are some of the entities which may combine to produce SIDS in a baby.

As Dr. Dexter Seto codified it, SIDS may be thought of as the final common pathway leading to death of the hapless infant.

There are many other conditions of man, the outcome of multiple factors, leading to a "final common pathway" and the well-known "down-hill course."

As certainly as a down-hill skier will reach the bottom of the hill—or be arrested in his flight, the SIDS victim may be inexorably on a down-hill course unless parents and physicians can become more alert to potential SIDS babies.

A family's guilt that they "did something wrong" and thereby brought about the death of their baby needs to be assuaged with appropriate counseling and psychological support.

Physicians, nurses and others who take care of babies professionally need to be alert to the problem of SIDS and to do what they can to get babies through the critical first 4 months.

There is now a Hawaii Chapter of the National Sudden Infant Death Syndrome Foundation, started by a bereft father in Connecticut not too many years ago. The national office is at 310 South Michigan Avenue, Chicago, 60604.

DRJ

## A Pain In The Neck

The radio blares: "Aloha! This is your friendly Doctor of Chiropractic, reminding you that our whiplash prevention treatments are cov-

ered 100% by No Fault Auto Insurance. So, if you are involved in any kind of auto accident, hurry in for free care to prevent painful problems from arising years from now."

This is really happening: Hawaii No Fault now covers chiropractic services! Since chiropractors have no qualms about advertising to solicit patients, and since no one wants to chance a pain in the neck, why not go in for free treatments? After all, you deserve something for your premium dollar.

It's easy to understand why the costs of body and fender manipulation will soon be surpassed by the costs of cervical manipulation. When the price of the average fender-bender has doubled, auto insurance premiums should, too. But who says preventive care comes cheap? Pity the thousands condemned to suffer prior to the bestowing of this marvelous, free prophylaxis.

*O tempora! O mores!*

JMC

## Here Comes Trouble

The chiropractors are girding for an all-out assault upon the state legislature, to gain recognition as health providers for insurance purposes. HMSA officials consider this the most serious issue yet to face medical care in Hawaii, not so much because of increased costs generated by another layer of "providers," but because waiting in the wings are colon-ologists, naturopaths, diet therapists, iridologists, vitamin counselors, astrologers, trichologists, masseurs, and hosts of opportunists ready to grab a share of the health dollar.

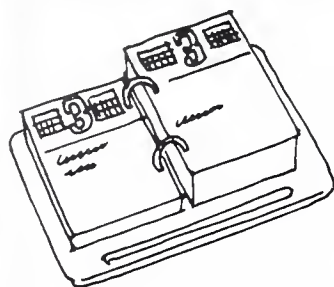
It's not easy to explain why third-party coverage shouldn't be provided for colonic oxygen therapy or diabetic spinal massage, but we have a clear duty to educate the public and legislature to the folly of accrediting and reimbursing these charlatans.

But meanwhile, we hear nurse practitioners, midwives, psychiatric social workers, paramedics, and others requesting independent practice, unsupervised patient care, hospital admission privileges, and direct reimbursement by patients and their insurers. Of vastly greater concern is our reaction to demands for recognition by these legitimate members of the health care team.

It's a confusing time for physicians: to remain open to suggestions for alternative medical care delivery—especially in the light of cost constraints—while protecting patients from quacks and from the well-meaning naiveté of those who assume that "a little knowledge" ought to be all that's necessary.

These are indeed perilous times. Challenging decisions lie ahead: some issues are clear-cut and easy. Others will be tough as hell for us to agree upon, much less convince the public, and we'll be damned either way. One thing is sure: medical care in Hawaii will be different in ten years; just *how* different depends on each of us today. The silly season approaches again. *En garde!*

JMC



## Continuing Medical Education

### CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

#### LOCAL ACCREDITED PROGRAMS

##### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Third Tues. w/Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. Dept of Medicine
  - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
  - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
  - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
  - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
  - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
  - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
  - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
  - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
  - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
  - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
  - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.

5. Dept. of Pediatrics
  - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
  - D. Neonatal Grand Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
  - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
  - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room 11).
7. Dept. of Surgery
  - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
  - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
  - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
  - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
  - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
  - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
  - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lihala St., 4th Floor Conference Room.

##### Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respcio, B.S.N. at (808) 537-5966.

##### Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

##### Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Fourth Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m.  
(Preventive Med.-Public Hlth. oriented.)



### **Kaiser Hospital**

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

### **Kapiolani-Children's Medical Center**

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

### **Kuakini Medical Center**

1. Guest Speaker, Second Monday, 1-2:00 p.m.
2. G.I. Conf. Third Tuesday, 8-9:00 a.m.
3. Dept. of Med. Mtg. (Med. Statistical Conf.) Fourth Tuesday, 1-2:00 p.m.
4. Nephrology Conf., Fourth Wednesday, 8-9:00 a.m.
5. Oncology Conf.-Tutor Oncologist, First Thursday, 7:30-8:30 a.m.
6. Oncology Conf., Second, Third and Fifth Thursdays, 7:30-8:30 a.m.
7. Surgical Conf., First, Second and Third Fridays, 12:45-1:45 p.m.
8. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
9. Surgical Conf.-CPC, Fifth Friday, 12:45-1:45 p.m.

### **Maui Memorial Hospital**

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

### **The Queen's Medical Center**

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
  2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
  3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
  4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
  5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
  6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
  7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
  8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

### **St. Francis Hospital**

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. Second Tues. ea mnth.

7:30 a.m. Sullivan 4-classroom.

4. SFH-UH Surgical Grnd. Rnds. Fridays (except Fourth), 7:30-8:30 a.m. Sullivan 4-classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. Fourth Fri., 7:30-8:30 a.m. Sullivan 4-Classroom.
6. SFH-UH Hematology Conf., Third Thurs. ea. mnth. 12:30-1:30 p.m. Sullivan 4-Classroom.
7. SFH-UH Renal Conf. First Monday ea. mnth. 7:30-8:30 a.m. Sullivan 4-Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.
9. SFH-UH Pulmonary Conf. Second and Fourth Wed. ea. mnth. 12:30-1:30 p.m., Sullivan 4-classroom.
10. SFH-UH Endocrinology Conf. last Monday ea. month 12:30-1:30 p.m. UH-4 Classroom.

### **Straub Clinic & Hospital**

1. Anesthesia Conference meets the Second Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the Fourth Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets First, Second and Third Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the Fourth Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the First Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the Third Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the Fourth Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the First Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the Second Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the Second Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the Fourth Thursday of each month from 7:00-8:00 a.m. in the DDR.

### **Wahiawa General Hospital**

1. Noon Seminars, Every Tuesday

### **Wilcox Hospital (Lihue)**

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, Third Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, First Monday, 5:00 p.m. dinner meeting and Third Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: I, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

### **SPECIAL EVENTS**

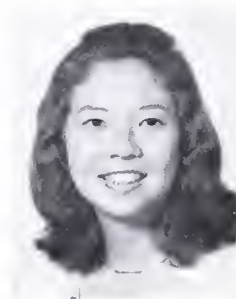
Nov. 11-16, 1979 Am. Congress of Rehabilitation Med., Sheraton-Waikiki Htl., Creston Herold, Exec. Dir. 30 N. Michigan Ave, Chgo. IL 60602.

- Nov. 18, 1979 "Stroke Seminar"—7:00 a.m.-3:30 p.m. Ala Moana Htl. HI Heart Assoc. 6½ hrs. credit Cat. I.
- Nov. 19-21, 1979 "Nutrition, Sex and Controversy." 6:30-9:30 p.m. Mon and Tues; 1-4:30 Wed. 10 hrs. Cat. I, no fee. Dept. of Ped., John A. Burns and Kapiolani-Children's. Contact: Wilma Schiner, Dir. of Training & Ed. 1319 Punahou St. Honolulu. 96826.
- Nov. 24-Dec. 1, 1979 International Seminar on Operative Arthroscopy. UCLA Ext. Serv., U of H Coll. of CME & Community Serv. co-sponsors. Kauai Surf Htl., 39 hrs. Cat. I.
- Nov. 27, 1979 "Fractured Families: What Happens To The Kids," Ala Moana Htl, Hibiscus Ballroom. 8 a.m.-4:30 p.m. HMA/HCMS Aux. 7 hrs. credit Cat. I. Contact: Mrs. John McDermott—955-6004 or Mrs. John Spangler—734-2925.
- Nov. 28-Dec. 1, 1979 Update: A Review of Current OB/GYN Practice, ACOG, Dept. of CME. Hyatt Regency Htl. 15 hrs. Cat. I.
- Dec. 6-9, 1979 American Medical Joggers Assn. Mr. Hugh S. Ames Honolulu Marathon Assn. P.O. Box 27244 Chinatown Station Honolulu, HI 96827 Hdq. Hotel: None selected Agent: Not appointed
- Jan. 6-13, 1980 Ultrasound Conference, co-sponsored by the Honolulu Medical Group, Research and Education Foundation, 18 Category I credit hours. Mauna Kea Beach Htl.
- Jan. 8-12, 1980 Intensive Review of Common Allergic & Asthmatic Diseases, U of Cal., Davis, Schl. of Med. Intercontinental Htl., Maui.
- Jan. 12-18, 1980 15th International Surgical Congress (Ten Surgical Specialties) Sheraton Waikiki, 20 Category I credit hours, Pan Pacific Surgical Association.
- Jan. 14-20, 1980 Estes Park Institute, Kauai Surf Htl., Ms. Tomi Wilson, Admin. Dir., P.O.Box 400, Englewood, CO 80110.
- Jan. 19-21, 1980 Common Obstetric and Gynecological Problems, co-sponsored by Tulane University School of Medicine, Department of Ob-Gyn, and Hawaii Section of ACOG, 15 Category I credit hours, 15 cognates ACOG.
- Feb. 1-4, 1980 Hawaii Review, co-sponsored by the Hawaii Chapter of AAFP, with invitation to BC Chapter College of Family Physicians of Canada, and Section of General Practice, BC Medical Association.
- Feb. 10-17, 1980 Otolaryngology Update, Hilton Hawaiian Village 10-14 & Kona Hilton, 14-17. U of C Dept. of Oto & Sacramento Soc. of Oto. Leslie Bernstein, M.D., D.D.S. P. O. Box 3213, El Macero, CA 95618.
- Mar. 1-8, 1980 American Urological Association, Western Section, King Kamehameha Hotel and the Sheraton Waikiki.
- Mar. 18-22, 1980 Sports Medicine, Department of Physiology, Princess Kaiulani, 18 Category I credit hours. J. A. Burns Schl. of Med. Contact: Harold Brown, Hawaii Conf. Serv. P. O. Box 25055, Honolulu 96825 (808) 377-6445.
- Mar. 31-Apr. 4, 1980 Current Concepts in Obstetrics and Gynecology, co-sponsored by the University of Washington, Dept. of Ob-Gyn and Hawaii Section of ACOG, Ilikai Hotel, 24 Category I credit hours, 24 cognates ACOG.

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## OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



**Cynthia J. Goto**

John A. Burns School of Medicine  
STUDENT—ASSOCIATE MEMBER



**Allen B. Richardson, M.D.**

1380 Lusitana Street  
Honolulu, Hawaii 96813  
ORTHOPEDIC SURGERY  
SPORTS MEDICINE



**Stephen L. Wee**

John A. Burns School of Medicine  
STUDENT—ASSOCIATE MEMBER





## Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

**New Members**—Robert K. Overlock MD is a new Active member by transfer from Texas and has joined the Waimea Clinic on Kauai. We welcome him to the Hawaii Chapter.

**Dropped from Membership**—are student members who graduated this year from the UHSM and received their MD's—Kamida, Sugiyama, Suyama, Warren and White who are probably going into specialized training.

**News of Members**—Gwen Nishimura MD has joined the Punawai Clinic as a practicing Family Physician. After several years of faithful service, Harold Machigashira has given up at Pohai Nani Retirement Residence in favor of Glenn Stahl, who is the current Home Physician. Our ex-prexy Tom Cahill let loose another blast at the Feds in a letter-to-the-editor (Star-Bulletin 10/4/79) in which he placed the blame for inflationary health care costs for the aged and indigent in terms of institutional care squarely on the government. In the same vein, Howard Liljestrang, in a private communication, deplores the governmental CME requirements that make it impossible for a retired physician to maintain his license if only to administer first aid (medical expertise or a hypo of morphine) to a group of hikers or campers of which he is a part. Perhaps the Hawaii Medical Practice Act should so exempt and stipulate.

**Local Dues**—will not be increased in 1980; so spake the Council at its September meeting at which the treasurer estimated the dues income of about \$2,000 would not be exceeded by much in the way of expenses if the dinner meetings continue to pay for themselves.

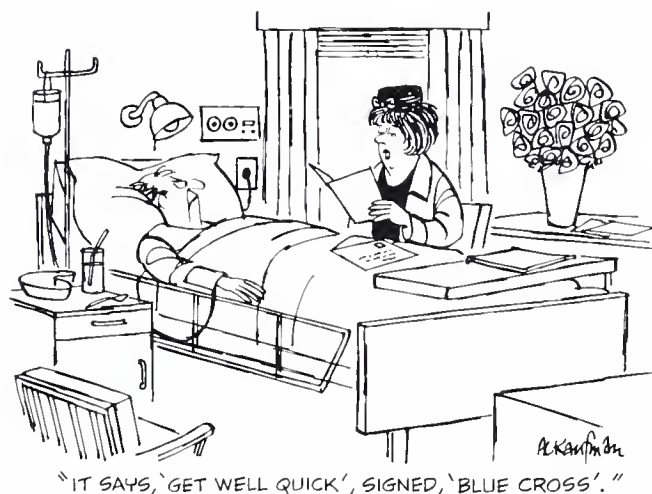
**Annual Meeting & Hawaii Review**—plans under the direction of president Pat Dietrich are proceeding smoothly. Members are reminded to sign-up and pay their \$25 downpayment to reserve a place for the 1-4 February 1980 joint scientific session with the British Columbia Chapter, Family Physicians of Canada at the Hilton Hawaiian Village. Our annual meeting, election of officers and installation of officers by AAFP president John S. Derryberry will take place that Saturday. Hawaii Review offers 34 hours of "P."

**CME etc.**—We obtained "P" credit for the AMA/HMA Regional Scientific Sessions the week of 8 Oc-

tober. We have asked AAFP for a special dispensation in order to announce in advance that the Pan-Pacific Surgical Congress 12-18 January 1980 sessions will offer "P" credit to AAFP members. The Kaiser program on 29 September was granted "P" credit, as was the Honolulu Medical Group's 19 October "Prescription Drug Misuse."

**Next Dinner Meeting**—will be held at the Don Farrell home in Haiku Gardens in Kaneohe on 10 November. Don has organized the program around "The Family and the Family Physician" for the first hour and "Demonstration of How to Interview a Family" for the second hour.

**Minnesota Chapter** is organizing a Seminar on Maui 20-29 January 1980 and invites Hawaii members to attend; it is asking for a Hawaii speaker.



"We Bring People Together"

PERSONNEL-ITY OF THE PACIFIC

Dear Doctor:

Just the other day, two physicians and I entered into a rather heated discussion as to why they never use a personnel placement service. The discussion went something like this:

Agencies send anyone and everyone in their files without knowledge or consideration as to experience in our particular field. We spend hours of wasted time interviewing needlessly. The agency is interested only in a fee, not our needs.

Apparently, they have cause to feel as they do.

As to a fee -- yes, as you charge a fee for service, so must we. However, our fee is set by State regulation. If you choose to pay the fee, that is between you and the applicant; otherwise, the applicant is responsible for the fee.

In summation, just let me say that it is apparent that the physicians have a point; therefore, we offer the following:

We will act as your personnel administrator. We will advertise for your specific needs. We will prescreen, test, and interview prospective employees, reducing the time you spend with an applicant to a final interview in your office.

Our professionally trained staff requests that we be allowed to serve your needs. Allow us the opportunity to prove that we can and will meet your specific needs.

Sincerely,

Paul S. Isenburg, Ph.D.  
Director  
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686



## **Clinical Pathologist's Easy Chair**

FRANCIS FUKUNAGA, M.D.

### **Viral Hepatitis Serology**

Prior to the discovery of the various serologic tests for hepatitis, the differentiation of hepatitis-A ("infectious hepatitis") from hepatitis-B ("serum homologous jaundice") was primarily based upon the epidemiologic history. The discovery of the test for the hepatitis-B surface antigen (HBsAg), formerly called hepatitis-associated antigen (HAA) and Australian antigen, changed the criteria for differentiating hepatitis-A (HA) from hepatitis-B (HB). The diagnosis of hepatitis-A was then made when the HBsAg was negative and there was no history of hepatotoxins nor transfusions, and hepatitis-B when the HBsAg was positive. The third category of hepatitis called non-A, non-B hepatitis has an epidemiologic history intermediate between HA and HB.

The HA virus is excreted in the stools for only short periods and in an infected patient and there is no known chronic carrier state, while the HB virus is not excreted in the feces but can cause chronic carrier states. The only practical method for diagnosing hepatitis-A is the detection of the antibody (anti-HA), because the patient usually has stopped excreting the virus in his stools when seen by his physician.

A single positive test is not helpful, because up to 45% of mainland Americans and 67% of the people in Hawaii are positive.<sup>1, 2</sup> Only the demonstration of a RISING TITER by serial measurements is of clinical significance. The first blood sample should be taken at the earliest suspicion of hepatitis and the second 2 to 3 weeks later. The illness can be considered not due to the HA virus if the test is negative and remains negative for about 8 weeks following the hepatitis-like illness.

The hepatitis-B virion (Dane particle) has a core containing DNA, DNA polymerase and a core antigen (HBc). The core is surrounded by a capsule that contains the surface antigen. This surface antigen can be removed and the residue can be used to induce core antibody formation. Because the surface antigen is merely an excess capsular material, the virus may be present and proliferate without producing the surface antigen. Special technics can demonstrate the core antigen in the nucleus and the surface antigen in the cytoplasm of infected liver cells. A third antigen called HBeAg is known to exist, but its origin is not clear at this time.<sup>6</sup>

The earliest detectable serologic finding in hepatitis-B infection is the HBsAg which appears during the incubation period and the early phase of the acute infection. This antigen may be detected in serum for only a few days in many cases, but may persist for months after clinical improvement. In the typical self-limited HB infection the HBsAg level drops over days or months. Where the HBsAg reverts to negative, it usually does so within 10 months; these patients are less likely to show transaminase elevation during the persistent antigenemia than those whose antigenemia persist for longer periods.<sup>3</sup>

The antibody to the hepatitis surface antigen (anti-Hbs) is usually detected weeks to months after the disappearance of the HbSAg, during convalescence from the infection. Anti-HBs in serum usually indicates previous infection and immunity.

The antibody to the core antigen (anti-HBc) is usually detectable in a patient during the acute infection and may be present after the HBsAg disappears and before the anti-HBs appears. Testing for both the HBsAg and anti-HBc are required to detect the maximum number of infected and possibly infectious individuals.<sup>4</sup> The presence of anti-HBc without either

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the HBsAg or the anti-HBs indicates (a) prior exposure to hepatitis-B virus, (b) the convalescent period of an acute infection or (c) the silent carrier state. It implies a recent or continual replication of the hepatitis-B virus in the liver. When both anti-HBs and anti-HBc are present, about 40% of the patients have tissue HB virus.<sup>4</sup> Chronic hepatitis-B carriers usually are positive for anti-HBc, DNA polymerase and HBeAg but the anti-HBs is not detectable.

The HBeAg, and DNA polymerase appear at about the same time as the anti-HBc. DNA polymerase is present transiently and early during the course of HB infection and may be detected in the absence of the HBsAg. The test for DNA polymerase activity may allow diagnosis of HB infection before other tests.<sup>5</sup> The HBe antigen is associated with ongoing viral replication; the presence of the antigen implies active liver disease. It can be detected in the acute or chronic infection and in the asymptomatic carrier. The detection rate of HBeAg declines with age while the anti-HBe rate increases with age.<sup>6</sup> The loss of the HBeAg in chronic progressive hepatitis is an important prognostic sign, indicating resolution of the illness.<sup>7</sup> HBe and anti-HBe are not detected in patients who lack detectable HBsAg.

The tests that are now routinely available are HBsAg, anti-HBs, anti-HBc and anti-HA. There at present is no test to exclude or diagnose non-A, non-B hepatitis.

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#### Review of Medical Physiology

By William F. Ganong, M.D. 618 pages. Lange Medical Publications, Los Altos, California. Ninth Edition, 1979. Price \$14.00.

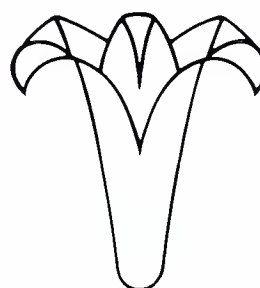
The 9th edition of this useful book on medical physiology arrives timely at its usual 2 year interval since the previous edition. It is now available in 13 languages as well as on tape.

A number of chapters and topics have been rewritten and expanded, among others those on vision, endocrine function of the pancreas, pituitary endocrinology, and intestinal absorption, to summarize well recent advances in these areas. The whole text is generously and lucidly illustrated. Many illustrations and references have been up-dated to include the most recent literature. The slightly larger print in this edition and the bold lettering improves the visibility of the text and facilitates the reading.

In short, this book provides an excellent source of information and reference on basic physiology and pathophysiology for students and physicians in training or practice. The 9th edition of REVIEW OF MEDICAL PHYSIOLOGY will no doubt continue its tradition of popularity.

WERNER G. SCHROFFNER, M.D.

## In Memoriam



**Ravinda Mashruwala, M.D.**  
**1947-1979**

Dr. Ravi Mashruwala, a member of the Hawaii County Medical Society, died at his home on July 9, 1979 at the age of 31. Dr. Mashruwala was born in Patan, Gujarat, India, on November 14, 1947. He is survived by his wife Mary; parents, Mr. and Mrs. Vinaychandra (Jayaben) Mashruwala; sisters, Mina Mashruwala and Mrs. Rajendra (Ashwini) Vakaria; and brothers Jayendra and Anil, all living in India.

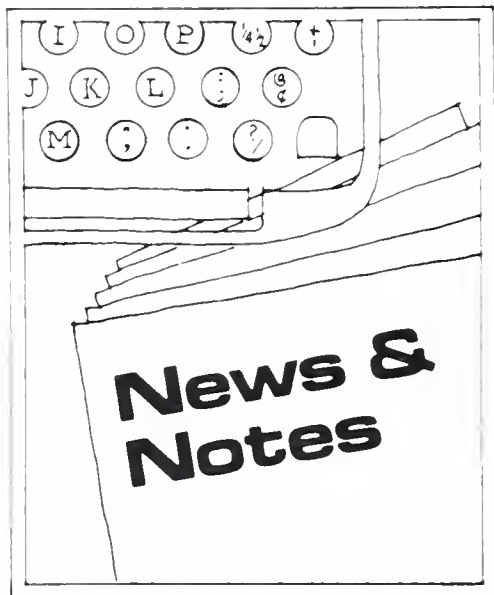
Mary and Dr. Mashruwala met on the campus of Wayne State University and were married in India on May 23, 1975.

Dr. Mashruwala received his medical degree from the University of Baroda in 1971. He then interned at Hutzel Hospital in Detroit, Michigan in 1972, completed a residency in internal medicine at Hutzel Hospital from 1973 to 1975. Dr. Mashruwala then finished a two-year fellowship in nephrology at William Beaumont Hospital in Detroit.

Dr. Mashruwala began his practice in Hilo in September of 1977. In his practice he emanated compassion and sensitivity for his patients.

He will be deeply missed by all, particularly by his family and colleagues.

A. SCOTT K. MILES, M.D.



HENRY N. YOKOYAMA, M.D.

## Memories. . .

While perusing The Queen's Vision, July 1979 issue, we were fascinated by a Sherrod Anderson's "A Day in the Life of an Intern" written 20 years ago for the Queen's Messenger. . . We have taken the liberty of reprinting the article in toto because it conjured up bitter sweet memories of our own Queen's intern days. . .

"Hints of a tropic dawn pale the night sky, as cool mauka

rains beat rhythmically against broad green leaves. A lizard chirps excitedly in answer to the awakening calls of ruffled birds in the wet trees. Trade winds stir through swaying palms. A ripening mango drops with a soft thud to the moist earth. . .

THEN THE TELEPHONE RINGS. . . "Hello (cough) Yes, this is he. What do you mean a gastric analysis at 6:30 in the morning. Are you sure this is a surgical case? I'll wait. Yeah. It is, huh. OK, OK. Yes, I'll be over. Good-bye. Oh, hello. Where is the patient?"

Another day begins. The great golden ball of the East floats slowly over the greygreen misty hills. Visible are the sparkling diamond droplets on the palm fronds. But within the cold grey edifice called Queen's, these precious moments are noted only by Westclock's circling hands and the new red and black-dots on a chart. . .

"Sorry I'm late sir, but I had to insert a Levine tube, and then they asked me to check a patient and start an I.V. and. . . (heh, heh) well yes, I did grab a cup of coffee, but it won't happen again sir. Yes, it was just an eight minute scrub, but I've always had unusually clean hands. Alright sir, five more minutes of scrub, then the sterile rinse. Here I am. Oh, you've already got it out. This retractor and this retractor. And hold this thread. And one more retractor, and CUT? Do you really mean it, sir? Oh, the thread. More exposure. Yes sir. I've still got three fingers I haven't even used yet."

Lights glare on in unchanging shadow, save the slight manipulation by some gowned and masked nurse who quickly responds to the gruff "How do you expect me to see with this light. I'm not an owl, you know. . ."

Standing, standing, standing. Feet flatten, varicosities bulge, noses itch and sweat trickles across furrowed brows and into blinking eyes—knowing it can't be touched by the holy rubber gloves. Then pau, the operation is over. Fingers unwind from retractors, curved shoulders straighten in uneasy stiffness, everyone thanks everyone. Except the unresponsive patient. Now, more scrubbing for the next operation. . .

So it's lunch time, that small oasis in a desert day when life seems almost normal. Good black coffee, steaming soup, roast turkey, mashed potatoes and banana cream pie quivering with goodness. Things aren't really so bad. . .

THEN THE TELEPHONE RINGS. . . "For me? (no comment) Yes? Come right now? But I've just started to eat. Oh, that's the reason you called the dining hall. Very clever. OK, OK, be right up."

The small green structure called Out-patient bulges with assorted humanity. With an "itai" here and "a come sore" there. Here's a sore, there is a sore, everywhere a sore sore. . . Back on the floors, OPD calls, politely insinuating that all interns not present must be playing pool, drinking coffee or sleeping. . .

THEN THE TELEPHONE RINGS. . . "So I have an H and P. You don't have to chuckle about it!" "OK, that's two more. . . " "Yes. Thank you. What? Ten more admissions? (no comment)."

Slowly as the Bombax cast its shadow toward Harkness, as the broad Pacific on the distant horizon turns metallic in the setting sun, a man strides from floor to floor in darkened halls and furtively steals a glance at the outside world. . .

"And what brought you to the hospital, Mr. Flufam? An ambulance. Yes, I see. What I mean is, why did you come to the hospital? Because the doctor said you should. Mmmm. Well, yes."

Finally the work is done. Each patient is readied for the next morning's procedures. A tired figure emerges from the building, hesitating in awe as the cool tropic breeze dispels the medicinal odors from his nostrils. A majestic moon rides through her starry subjects. The night birds coo in the comfort of its beauty. . .

In his room, he removes the not-too-bloodied white uniform and wonders briefly if it will last another day. The cool sheets are warmed by his silent form as soft winds carry late hour chimes from some distant tower to conjure up dreams of days before. . .

THEN THE TELEPHONE RINGS. . .



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## Miscellany (As gleaned from a KIIIVH broadcast)

Two psychiatrists passed each other in the hospital corridor. One said, "Good morning." The other was puzzled, "Now, what did he really mean by that remark?"

President Carter was fishing on a canoe when a rabbit scurrying away from a predator hopped into the water and started to swim toward the president's canoe, making a strange hissing sound. The President raised his paddle and hopped the rabbit when it tried to get into the canoe. When the newspapers broke the story, the National Association for the Protection of Wild Life howled: "Paddles don't kill rabbits! People do!" (Ed. Do you get the same feeling that we sometimes missed the point of the joke?)

## Visiting Professors . . .

**J. Willis Hurst**, professor of medicine, chairman of Dept. of Medicine, Emory University, School of Medicine was here in August and spoke on "The Value of Coronary Bypass Surgery." We gathered the following gems:

"Everybody agrees that 90% of patients with angina pectoris get relief with by-pass surgery . . . But there is disagreement regarding *survival time* or prolongation of life with by-pass surgery . . . ie, the frequency of sudden death, CHF, recurrent MI's, etc . . . The true scientist will never say this is absolutely true . . . only the pseudoscientist does . . . We should be careful not to make demands which cannot be proven absolutely . . . In preinfarction Angina (pre-propranolol), the first year survival was 18% and the 4 year survival was 65%. With by-pass surgery, the first year mortality was 95% and the 4 year survival 90% . . . With medical treatment, sudden death is three times greater than in post surgical cases . . . re, survival! In single vessel disease, we cannot show any difference with surgery and medical treatment in a general population curve . . . In the surgitized population, the survival curve may be even better than the general population survival curve . . . whereas in the medically treated population, with stable angina, (even those treated with propranolol), the survival curve does not come close to the general population curve . . . Stable angina, 11 main coronary, VA randomized studies: Medical treatment 60% survived 36 months while with surgery, 85% survived 36 months . . . Chronic angina, triple vessel disease, VA studies: 70% survived 60 months with medical Rx while 92% survived 60 months with surgery. Results at Emory University with 11 main coronary disease: 60% survived 36 months with medical Rx 90% survived with surgery . . ."

## Physicians Speak Up

Our favorite social commentator **J. I. Frederick Reppun**, Md has this to say about the recent "blu flu" (ie, the recent police sick-out): "Cure sought for Sick-out Ploy" was the headline over an article (6/23). It quoted Harry Boranian, city civil service director, as saying, rightfully, that sending employees to city & county physicians doesn't help matters in the case of the "blu flu," or of strikes, because the doctors, for many reasons, are willing to sign the medical excuse slips. . .

"The reason I write this letter is the needless escalation of the cost of health care through an insistence on the medical excuse slip. Government is perhaps the worst offender in this, because it exerts the force of law. In order to claim sick leave, the government employee is forced to pay money directly out of pocket or indirectly through his insurance, in order to go see a doctor and persuade him to sign a slip saying the employee was sick from this date to that one. The honest or truly sick employee is thus assumed to be guilty of malingering until he gets his doctor to prove that he really is sick.

"The doctor's signature to this document is never challenged, even though that physician can no more see or feel a pain or a symptom than can any lay person even a judge. Very few illnesses show objective signs—such as an obvious angulated broken leg. Most of the time the physician must trust and believe his patient. A dishonest patient can fool or cajole any one. Doctors, being emphatic towards those who claim to

be miserable, are even more gullable than most people . . ."

"Boranian is not the only one who washes his hands of the whole matter after he puts the monkey on the doctor's back. All industry and all employers do it too. It is very true that the one dishonest malingerer spoils it for all the honestly sick and injured, causing such blanket rules to be applied to all. However, it is time that government/industry/employers come to realize that it is neither just nor fair to burden and penalize physicians in the matter of certifying sick leave."

"I suggest the rules and laws be changed so as to allow each employee to take an oath as regards his own disability from work, if it is for a medical reason with which he can cope without going to a doctor; and that the certifying process requiring a doctor's signature be reserved for the really serious and long time disabilities. Then, let's see how many policemen and firemen and teachers are "honest" when they claim to have the "blu flu;" let *their* consciences be *their* guides."

"Please leave us doctors out of squabbles at the bargaining tables." (Ed: And we all echo your sentiments, Fred)

## Osler's Aphorisms . . .


The chief function of a consultant is to make a rectal examination that you omitted . . .

One of the first duties of the physician is to educate the masses not to take medicine . . .

Man has an inborn craving for medicine. Heroic dosing for several generations has given his thirst a thirst for drugs . . . The desire to take medicine is one feature which distinguishes man, the animal, from his fellow creatures . . .

Remember how much you do not know . . . Do not pour strange medicines into your patients . . .

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Ignorance is the conceit that a man knows what he does not know . . .

The young physician starts life with 20 drugs for each disease and the old physician ends life with one drug for 20 diseases . . .

Who can tell the uncertainties of medicine as an art? . . .

Errors in judgement must occur in the practice of an art which consists largely in balancing probabilities . . .

One is never very surprised or angry to find that one's opponents are in the right . . .

## Our "Angels"

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## Rules of Surgery in Private Practice

**"Some things borrowed,  
some things new, and  
Hopefully, some things funny, too—"**

*By: John Lacakadoo*

1. The two absolute indications for surgery are:
  - a) the operation's really necessary;
  - b) you need the money.
2. The hardest thing about surgery is getting the referral.
3. God created consultants to share the blame.
4. Don't let science get in the way of good surgical judgment.
5. The patient usually appears the worst, just before he dies.
6. You're too old or tired to operate if you can't appreciate the scrub nurse's boobs.
7. You're not concentrating if *all* you notice *are* those boobs.
8. Anesthesiologists get too little of the credit, and too much of the blame.
9. Bleeding is the only defense of the anesthetized patient against the hapless surgeon.
10. Be wary of the surgical resident who doesn't like to operate.
11. Good surgeons have one thing in common—deep down, they believe they're the greatest.  
    . . . and for good luck . . .
12. The sincerest form of tribute is when that cautious *Paké* lady says to you, "Doctah, OK you opelate me. Make-ee me beautiful."

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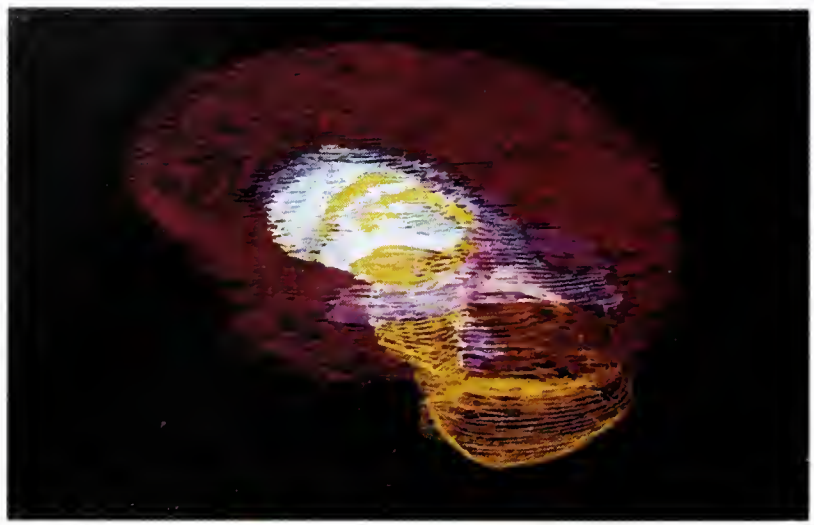
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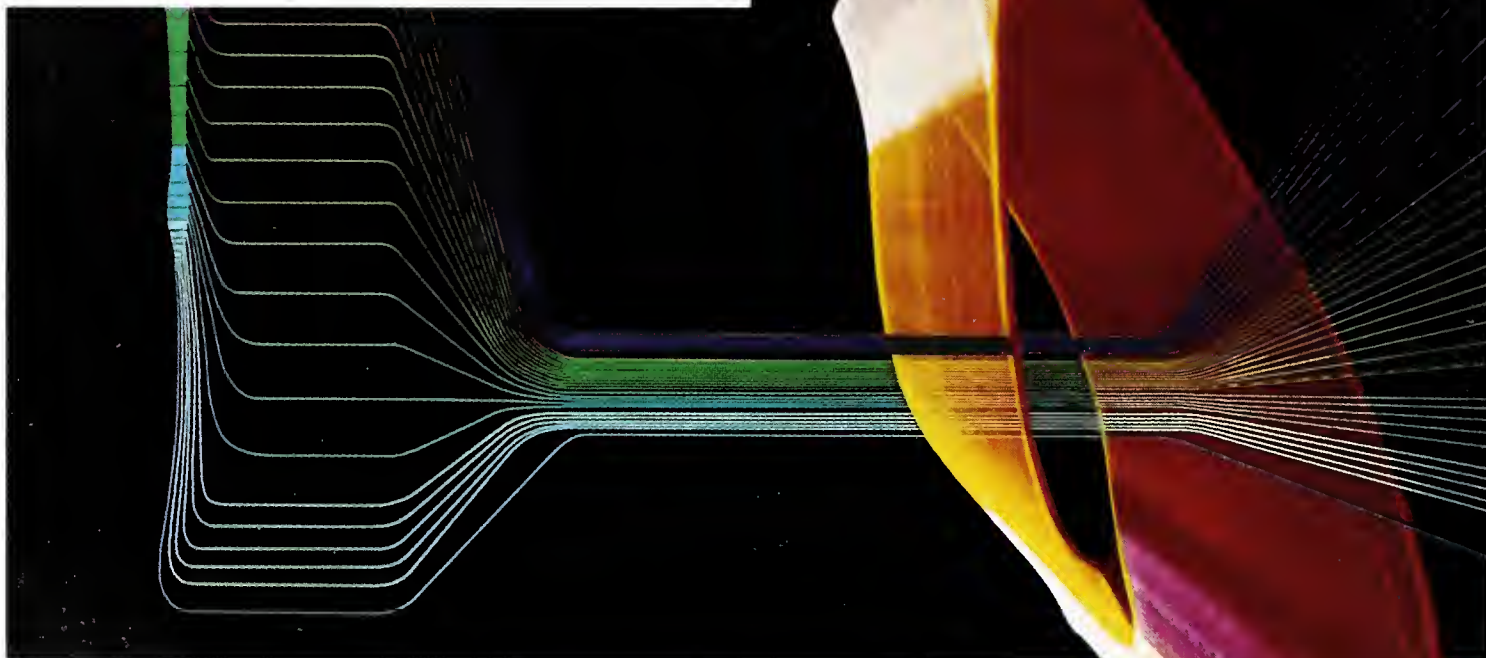
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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants

may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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# The Maker

## Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



*MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.*

**FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were**

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

*MYTH: Industry favors only "expensive" brand names and denigrates all generics.*

**FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.**



# Matters.

**MYTH:** Generic options always exist.

**FACT:** About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for every 45 percent of such expenditure, is a generic prescribing option available.

**MYTH:** Generic prescriptions are filled with expensive generics, thus saving consumers large sums of money.

**FACT:** Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from the same sources, in the best interests of patients. In most cases the patient receives the same proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

**MYTH:** Drugs account for a major portion of the rise in health care costs.

**FACT:** Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

**MYTH:** Government intrusions into the marketplace will save tax money.

**FACT:** Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

## The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

## The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



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# Clostridium Perfringens Cultured From a Hawaiian Sardine, Sardinella Marquesensis

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● *Clostridium perfringens*, one of the clostridia responsible for gas gangrene and a bacterium causative of at least one type of bacterial food poisoning intoxication, was cultured anaerobically from a Hawaiian sardine, *Sardinella marquesensis* (Berry and Whitehead, 1968). There are several noteworthy public health ramifications of this finding.

Sardines in general have been associated with a significant variety of human clinical disorders, including, but not limited to, fish allergy or anaphylaxis,<sup>1-2</sup> clupeid or clupeoid poisoning (i.e., clupeotoxication by ingestion),<sup>3-11</sup> ciguatera fish poisoning,<sup>12-14</sup> scombroid-type poisoning (i.e., histamine overdose scombrototoxication ingestion, but by a non-scombroid fish),<sup>15</sup> fishfin puncture wounds, fishbone trauma, *Vibrio parahaemolyticus* bacterial food poisoning (e.g., Shirasu sardine food poisoning),<sup>16-18</sup> micrococcal bacterial food poisoning,<sup>19-20</sup> and *Clostridium botulinum* bacterial food poisoning (e.g., Type E botulism).<sup>21-23</sup>

Several of these pathological conditions have been ascribed to specific species of sardines, such as the sardines listed as being evocative of the clinical manifestations of clupeid poisoning<sup>10-11</sup>

and ciguatera fish poisoning.<sup>12-14</sup> However, the sardine recently classified as *Sardinella marquesensis* has not been fully evaluated prospectively as to its roles in the spectrum of sardine-induced sicknesses in man.

The Marquesan sardine, *Sardinella marquesensis*, was initially introduced into Hawaii in 1955 (as a bait fish for tuna fishermen) under the name *Harangula vittata* (Cuvier and Valenciennes).<sup>24</sup> It was later discovered to constitute an undescribed species. Later it was described and named *Sardinella marquesensis* (in 1968),<sup>25</sup> and was subsequently studied biologically in this name.<sup>26</sup>

Of more than 150 species of fishes in the herring fish family, at least two species are native to Hawaii (the round herring *Etrumeus micropus* [Schlegel, 1846] and the small round herring *Spratelloides delicatulus* [Bennett, 1831]). At least two species were introduced into Hawaii (the gizzard shad *Dorosoma petenense* [Gunther, 1868] and the Marquesan sardine *Sardinella marquesensis* [Berry and Whitehead, 1968]; these were brought in in 1955 and 1958, respectively).<sup>24</sup> The Marquesan sardine has been described as the "first imported marine fish to become established in the Hawaiian Islands."<sup>24</sup> As a relatively newly-classified sardine, *Sardinella marquesensis* is in need of scientific evaluation as to its potential spectrum of associated human clinical disorders, relative to those previously reported for sardines in general.

In this study, one Marquesan sardine caught in Hawaii was cultured aerobically and anaerobically for bacteria assess preliminary to its potential role in human bacterial food poisoning.

## Materials and Methods

A Marquesan sardine was caught by Mrs. Y. Takekuma on October, 21, 1978, at the Port

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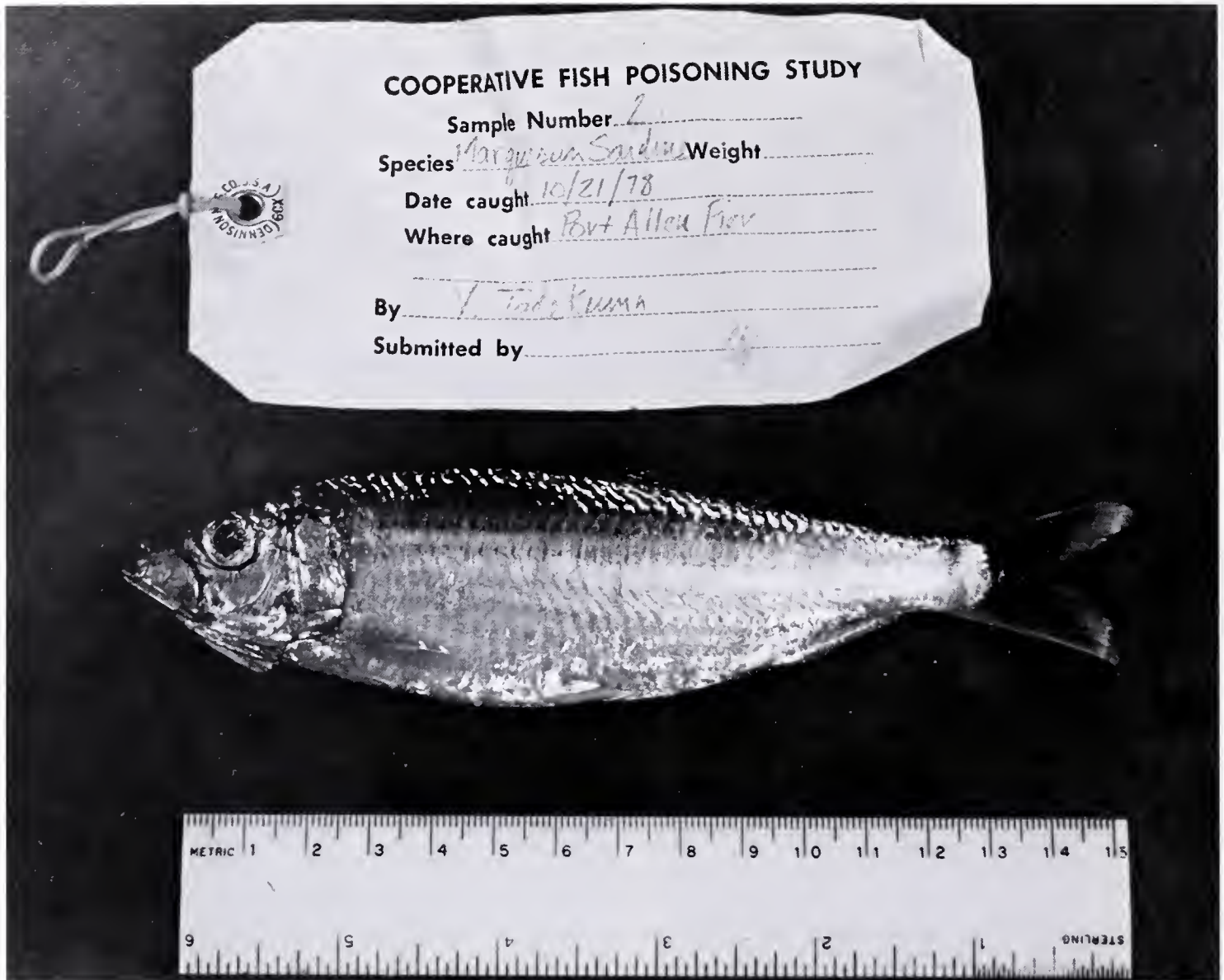
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FIG 1.—The Marquesan sardine, *Sardinella marquesensis* Berry & Whitehead, 1968. Actual specimen used in this study. Medical Photography by Roy Cameron, Queen's Medical Center, Honolulu.



Allen pier, Kauai, Hawaii, and was submitted to one of us (RJM) as a part of a cooperative fish poisoning study. The fish was similar to those identified earlier in October, 1978, from Kauai, as *Sardinella marquesensis*, by Dr. John E. Randall of the Bishop Museum of Honolulu. The fish was wrapped, labeled Marquesan Sardine sample number 2 and was deep frozen. It was transferred in a frozen state to Honolulu on November 6, 1978, where it was deep frozen to minus 80-90°C. The fish was removed from the freezer on January 3, 1979, unwrapped under sterile conditions, and dissected (on the right side) under sterile conditions while the fish remained frozen. The following sardine tissues were rapidly collected under individual sterile conditions for subsequent aerobic and anaerobic cultures: skin (outer integument plus subcutaneous fat layer), liver, roe, and stool (with the bowel being dissected out last). Sterile saline (Sodium Chloride Injection USP, McGaw Laboratories, Irvine, California, 250ml, S4002-J8L071A Exp Sept 1980) was submitted as culture controls.

After a 1.5 hour thaw following the tissue collection for bacterial cultures, the fish was

wiped dry, measured, briefly described, and photographed. The fish was 16.4 cm in length (nosetip to distal tailtip) overall, and 15.0 cm in length from nosetip to tail distal cleavage. The sardine was silvery white, with dorsal greyish-blackness and a greenish-black tail. Color, as well as black and white photographs were made of the left side of the fish (Figure 1).

The tissues from the sardine, as specified above, were cultured aerobically and anaerobically. Culture broths for each separate tissue specimen from the sardine, as well as the saline controls, were examined daily for turbidity and gas bubble formation. Gram stains were performed as necessary.

The bacteria recovered were separated, identified, and speciated using standardized procedures.<sup>27-29</sup>

## Results

Bacteria were recovered from each of the sardine tissues cultured. There was no growth of bacteria from the sterile saline controls. The bacteria cultured and identified from each of the



TABLE 1.—Marquesan Sardine Bacterial Flora

SKIN	<i>Clostridium perfringens</i> <i>Clostridium</i> sp. (1) <i>Clostridium</i> sp. (1) <i>Pseudomonas</i> sp. <i>Acinetobacter</i> sp. <i>Staphylococcus epidermidis</i> <i>Bacillus</i> sp.
STOOL	<i>Enterobacter hafnia</i> <i>Staphylococcus epidermidis</i> alpha hemolytic streptococci
LIVER	<i>Staphylococcus epidermidis</i> alpha hemolytic streptococcus viridans
ROE	<i>Staphylococcus epidermidis</i>
CONTROL	No growth

specified sardine tissues are summarized in Table 1, including those bacteria which could not be speciated. The sardine tissue culture broths became turbid within short periods of time for the following: feces (within 24 hours), skin (within 24 hours), roe (within 48 hours). Gas bubble formation was noted in the culture broth tubes within 48 hours for the sardine skin and sardine stool specimens. Doubly hemolytic *Clostridium perfringens* was obtained from the sardine skin cultures, as were several other organisms (see Table 1). Two varieties of Clostridia, not *C. perfringens* and not *C. botulinum* were obtained from the sardine stool cultures, as well as other bacteria (see Table 1). Although *Vibrio parahaemolyticus* and other vibrios were prospectively sought for in each of the cultures, no vibrios of any kind were recovered from any of the samples of the specified sardine tissues of our Marquesan sardine sample number 2.

## Discussion

*Clostridium perfringens* was obtained from an anaerobic culture of the skin of a Marquesan Sardine caught at Port Allen, Kauai, Hawaii in 1978. This *C. perfringens* exhibited both anaerobic gas production and double hemolysis. Two other clostridia, not *C. perfringens* and not *C. botulinum* were also recovered. No *Vibrio parahaemolyticus* was recovered.

A primary problem in poisoning of humans by ingesting sardines is the fact that many types of human illness can be caused by sardines, including ciguatera fish poisoning. In ciguatera fish poisoning, there is a hemolysis associated with the maitotoxin associated with the ciguatoxin in the fish tissues.<sup>30-31</sup> Hemolysis in sardine poisoning, then, may be from the *Vibrio parahaemolyticus*, several clostridia, or ciguatera fish poisoning.

## Conclusion

*Clostridium perfringens* was recovered from the skin of a Kauai Sardine *Sardinella marquesensis*. Appropriate public health measures should be taken, including careful utilization of these sardines for bait fish by fishermen.

## Acknowledgements

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# The Effects of Freezing and Pasteurization on Human Milk

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● *The effects of freezing and pasteurization on the sodium, osmolality, macrophages, lymphocytes, immunoglobulin and bacterial colonization in human breast milk were studied. We found significant alteration in the total macrophage and lymphocyte count, and in the immunoglobulin concentrations following freezing and pasteurization. Sodium concentration and osmolality were not significantly changed following similar processing. Pasteurization resulted in significant decrease in bacterial colonization.*

The nutritional management of the sick newborn has become increasingly important, as more survive with improved intensive neonatal care. Recent evidence suggests that human breast milk contains immunologic and biochemical benefits for such infants.<sup>1,2,3,4,5,6,7</sup> Possible factors include immunoglobulins, lymphocytes, macrophages and osmolality.<sup>8,9,10</sup> Providing sufficient quantities of such milk involves breast milk banking.<sup>11</sup> The purpose of this study is to investigate the effects of freezing and pasteurization of human milk.

## Material and Methods

Samples of human milk were collected by the Hawaii Mothers Milk, Inc., during the period of May, 1976, to July, 1976. Informed written consents were obtained from 20 individual donors of multiracial and ethnic backgrounds with a mean age of 28.2 years. All donors had been nursing

for more than 30 days and were carefully screened regarding their general health and use of current medications. Appropriate samples of milk in fresh, frozen, and pasteurized state were analyzed for sodium, osmolality, macrophages, lymphocytes, immunoglobulins, and bacterial colony count by the Kauaikeolani Children's Hospital laboratory.

Fresh milk was defined as that being tested within 60 minutes of collection. Frozen milk was defined as that being stored for 30 days at -17.7°C, and then tested within 60 minutes after being thawed in room temperature. Pasteurized milk was defined as that being heated to 73°C for 3 minutes after being frozen for 30 days.

Donors expressed their milk manually in the office of the Hawaii Mothers Milk, Inc. All milk samples were foremilk, and were collected in 5 ml sterile plastic vials to prevent loss of components by adhesion.<sup>12</sup> Table 1 lists the method used in each determination.

TABLE 1.—Laboratory methods

TEST	METHOD
Sodium	Flame photometer (1 L #343) <sup>13</sup>
Osmolality	Osmometer (Wide Range Osmometer Model 3W Advance Instruments, Inc.)
Immunoglobulins	Radial Immunodiffusion Test <sup>14,15</sup> (Hyland)
Macrophages and Lymphocytes	Direct cell count, using the phase microscope with a Neubauer hemocytometer
Bacterial Count	Colony count blood plate using 1/100 loop <sup>16</sup>

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Standard statistical methods were used to evaluate the data, including t-tests to determine pairwise differences.

Results

Table 2 lists the mean values of the sodium concentration, osmolality, macrophage-lymphocyte concentration, and immunoglobulins before and after processing, while Table 3 shows the statistical analysis using a t-test.

TABLE 2.—Mean values

	FRESH	FROZEN	PASTEURIZED
Sodium (MEq/liter)	16.45	16.75	16.73
Osmolality (mOsm/kgH <sub>2</sub> O)	289.90	288.65	288.55
Macrophages (cells/mm <sup>3</sup> )	45.50	0.90	1.70
Lymphocytes (cells/mm <sup>3</sup> )	17.75	2.80	.95
IgG (mg/dl)	11.05	8.95	.40
IgM (mg/dl)	14.00	13.05	0
IgA (mg/dl)	57.35	41.85	.75

*Physical Properties.* The sodium values ranged from 2 to 102 mEq/l, with a mean of 16.45 mEq/l, while the osmolality ranged from 267 to 301 mOsm/kgH<sub>2</sub>O, with a mean of 289.90 mOsm/kgH<sub>2</sub>O in the fresh specimen. Freezing and pasteurization did not significantly alter these values.

*Colony Count.* Of the fresh milk samples, 85% (17 of 20) were contaminated with bacteria, predominantly *Staphylococcus epidermidis*. Of the frozen samples, 70% (14 of 20) showed similar colonization. After pasteurization, only 15% (3 of 20) of the milk samples contained demonstrable amounts of bacteria, in concentrations less than 100 colonies/ml.

*Cellular Components.* The direct cell counting of the macrophages in the fresh, frozen and pasteurized samples showed a mean concentration of 45.50, 0.90, and 1.70 cells/mm<sup>3</sup> respectively. The lymphocyte count in the fresh, frozen and pasteurized specimens showed 17.75, 2.80, and 0.95 cells/mm<sup>3</sup> respectively. There were significant differences between the fresh and the frozen samples, and between the fresh and the pasteurized specimens.

*Immunoglobulins.* The mean concentration of IgG, IgM, IgA in the fresh milk specimen were 11.05, 14.00 and 57.35 mg/dl respectively, while the concentration in the frozen milk of IgG, IgM,

and IgA were 8.94, 13.05, and 41.85 mg/dl respectively. Following pasteurization, the IgG, IgM, and IgA concentration were 0.40, 0, and 0.75 mg/dl. The IgG, IgM, and IgA showed significant differences between the fresh and pasteurized specimens, and between the frozen and pasteurized specimens.

Discussion

Milk banking is a practical means of providing sufficient quantities of human milk. Recent studies however, have shown that processing breast milk has undesirable effects on the immunoglobulins and cellular components. Ford *et al.*<sup>17</sup> reported a 20% reduction of IgA titers and almost complete destruction of IgM following pasteurization at 62.5°C for 30 minutes. Increasing the temperature resulted in a corresponding decrease in the IgA. Liebhaber *et al.*<sup>18</sup> found similar results with the immunoglobulins following heat treatment, although they could not find any significant alterations of the IgA content following freezing for 4 weeks. They also demonstrated a significant decrease in the total lymphocyte count following freezing and pasteurization. The data from this investigation agree that freezing and heat treatment result in a significant loss of macrophages and lymphocytes, as well as IgG, IgM, and IgA. Our quantitative results of the immunoglobulin did differ from the other workers. This may be due in part to the method used in the collection, i.e., glass vs plastic containers, foremilk vs hindmilk; and in the processing, i.e., pasteurization at 62.5°C for 30 minutes vs 73°C for 3 minutes, and freezing at -23°C vs -17.7°C.

The sodium concentration<sup>12</sup> and osmolality<sup>19</sup> in our studies compared favorably with those reported in the literature, and were not affected by processing. However, the individual readings ranged widely, especially the sodium content. Peitersen<sup>20</sup> showed similar individual variations although to a lesser degree. Of the 4 mothers with breast milk sodium greater than 25 mEq/l, 3 were Caucasians and one Oriental. Interestingly, those milk that contained higher sodium level also had higher colony counts, suggesting a possible relation to the collection process.

Although our study showed that processing

TABLE 3.—Values of t-test (each with 38 degree of freedom) and tail probabilities for comparing pairs of samples. Pair of Samples Compared

	FRESH VS. FROZEN		FRESH VS. PASTEURIZED		FROZEN VS. PASTEURIZED	
	T-TEST	P-VALUE*	T-TEST	P-VALUE*	T-TEST	P-VALUE*
Sodium	0.17	>0.80	0.01	>0.90	0.17	>0.8
Osmolality	0.45	>0.50	0.45	>0.50	0.03	>0.8
Macrophages	2.37	<0.04	2.32	< .04	0.57	>0.5
Lymphocytes	4.32	<0.001	5.33	< .00001	1.22	>0.2
IgG	0.52	>0.5	4.08	< .001	2.75	<0.01
IgM	0.13	>0.8	2.41	< .03	3.07	<0.005
IgA	0.54	>0.5	2.88	< .01	1.96	<0.05

\* > stands for greater than, < stands for less than  
Note: P-value less than 0.05 implies significance at 5% level

did not alter the sodium osmolality level, further investigation is needed in terms of the individual variation among donors since the recipients of the milk may be infants with compromised renal function.

The importance of controlling bacterial colonization of banked milk has been pointed out by Ryder<sup>21</sup> *et al.* The technique of collection has a great influence on such colonization.<sup>22</sup> Donors in our study expressed their milk after being carefully screened and instructed by public health nurses. While every effort was made to insure aseptic technique, our study showed the presence of bacteria in 85% of the fresh milk, and in 70% of the frozen specimens, although in low concentrations. The significance of these organisms, many of them non-pathogenic, is not known at this time. Because higher bacterial concentrations would be expected under less controlled conditions, we feel that microbial surveillances of all banked milk is necessary.

Further research is needed to develop a technique that will provide human milk in readily available quantities that can be stored for long periods of time, without disturbing the beneficial biochemical and immunological properties of such products, while maintaining a safe microbial level.

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# Poisoning Incidents in Hawaii

C. LOREN CUMMONS, P.A., M.P.H., and LYLE WONG, Ph.D., *Honolulu*

• *Since the Poison Control Center opened in 1957, the volume of incoming calls concerned with poisoning incidents has increased substantially, from 268 during the first year to 6,685 during the study period from June, 1977, to July, 1978. A systematic sampling of 672 records during the study period revealed the following information: Incidents occurred most frequently from 6:00-9:00 p.m. Children under 5 years of age are most frequent victims, with ages 2 and 3 representing the highest proportion of incidents. Adults with symptoms usually delayed their calls 6 hours or more after the incident took place. Most incidents were accidental and occurred by ingestion. Household products and non-prescription medicines were implicated in the highest number of poisoning incidents. There was a disproportionately large number of incidents reported among military personnel and dependents. A concentration of incidents occurred in downtown Honolulu and on or near military bases.*

A review of a sample number of records at the Poison Control Center, now known as the Hawaii Poison Center (HPC) at Kapiolani Children's Medical Center from June, 1977, to July, 1978, indicates an overall increase in poisoning incidents in Hawaii. However, patterns have changed primarily because of preventive measures, public education and laws on labeling of ingredients on household products. In 1957, when the Poison Control Center was established at Kapiolani Children's Hospital, there was an urgent need for providing information on management and treatment of accidental poisonings in children.

The center was primarily designed as a focal point for the dissemination of information on poisons. The hospital was equipped to handle actual cases of poisoning, but management of cases of poisoning was limited to children. However, information was available to all patients regardless of age.<sup>1</sup>

During the 2 decades of its existence, the volume of incoming calls concerned with

poisonings has increased substantially, from 268 in the first year to 6,685 during the study period from June, 1977, to July, 1978. Based on the total population (estimated), these figures represent more than a 10-fold increase in the volume of reported poisoning incidents: 1 in 1,700 persons in 1957 as compared with 1 in 130 in the study period. Related to this increase, current trends in poisoning incidents are described.

## Methods

The chief source of information on poisoning incidents is telephone calls. Incoming calls are recorded on special forms. Data retrieval on toxins is from file cards, texts, manuals and other indexed material in the Center. Pertinent information recorded on calls consists of: date and time of call, time of incident, age and sex of victim, place of incident, telephone number and identification of caller (name optional), suspected substance, identification of substance, symptoms and route of contact and the antidote or emergency measures recommended.

A systematic sampling method was used with every tenth record being selected for review. Information was tabulated only for calls in which a human poisoning incident had occurred. The sample size was 672, or 10.1% of 6,685 calls. Data were tabulated by age and sex, route of contact, substance(s) identified and distribution of incidents in the State. Blanks or unavailable information were tabulated in the appropriate "unknown" columns. Identification of callers were categorized by the following characteristics defined by the Center:

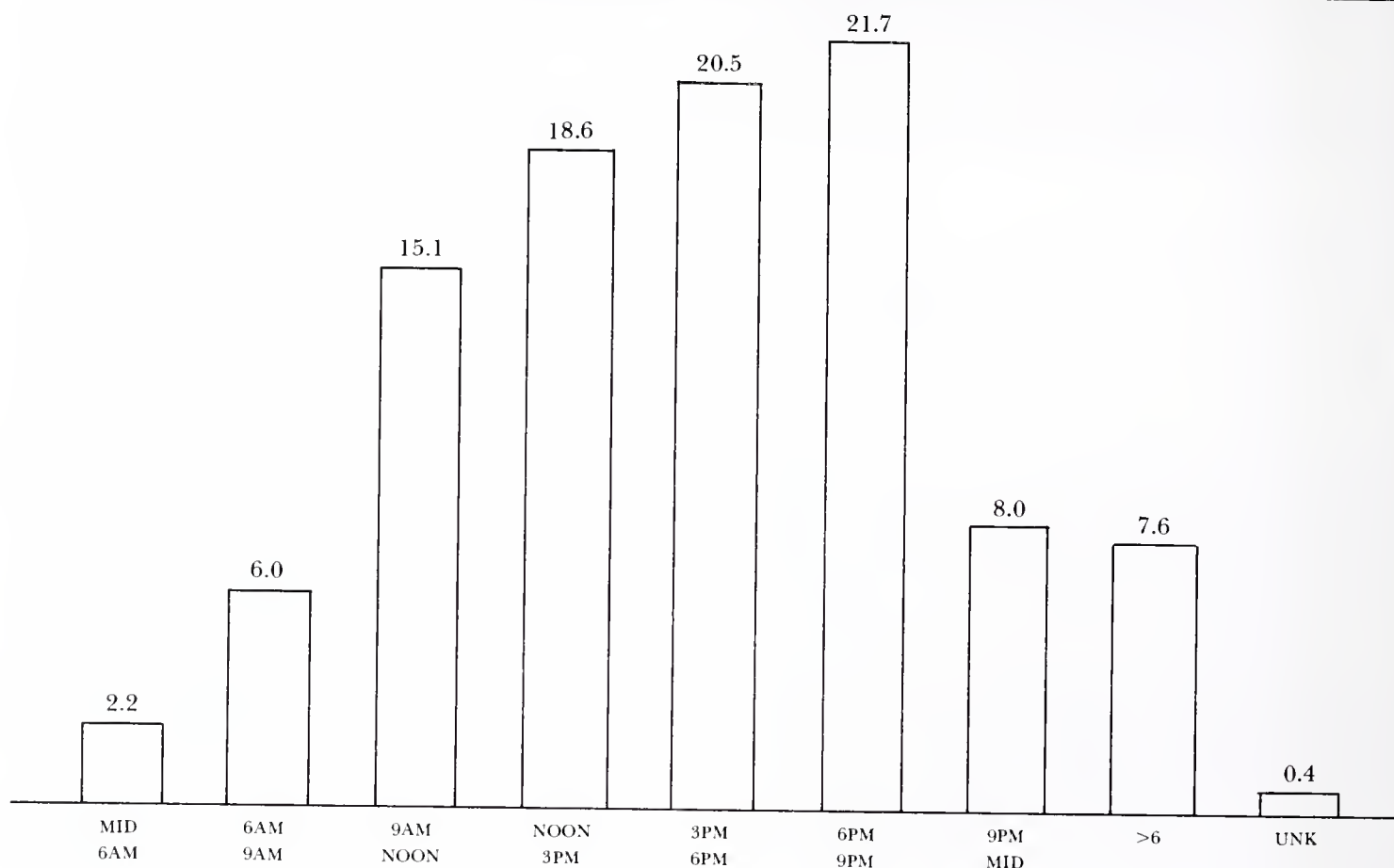
Professional caller: M.D., D.D.S., D.V.M., R.N. or corpsman, when acting in their capacity in providing treatment for a poisoned victim.

Lay caller: any member of the general public. This could include professional persons when calling for themselves or others when outside of their clinical setting.

Poison: any substance one can ingest, inhale or touch that is thought to cause harm or death.

University of Hawaii, Pacific Biomedical Research Center, Hawaii Epidemiologic Studies Program  
Accepted for publication May, 1979.

FIG. 1.—Percent of poisoning incidents during specific time periods.



Poisoning incident: an incident is considered to have occurred when a caller believes that he or others have had contact with a poison.

Symptom: any physical complaint that the caller feels is related to the poison contacted.

The last three definitions are broad, but necessarily so, because of a lack of greater diagnostic criteria available in this setting; clinical impressions and laboratory analysis are not available to lay callers, who make up 62.3 percent of the incidents. Therefore, some substances are not taken in toxic doses or perhaps not at all, or are not toxic; however, according to these broad definitions a poisoning incident has occurred.

## Results

Of 672 calls sampled, 502 (74.7%) related to human poisoning incidents. Of these 502 calls, 26 (5.2%) were multiple incidents involving an additional 36 people making a total of 538 poisoning incidents. Figure 1 shows the distribution of incidents over a 24-hour period as well as delayed and unknown incidents. It should be noted that there is a gradual increase in the proportion of incidents from midnight until 6:00-9:00 p.m. when a peak is reached. Delayed incidents are represented by calls received more than 6 hours after the incident took place. In this category 87.8 percent were symptomatic; 61.0 percent were in adults.

The distribution of incidents by age is presented in Table 1. The cumulative percentage shows that half (49.9%) of the incidents occurred among children less than 5 years of age. The second and third years of life are the times a child is most likely to contact a poison; the annual rates (%/yr.) at these ages were more than twice that of any other age group, 16.4 and 15.9, respectively. School age children and teens are less likely to be involved in a poisoning incident. There was an equal distribution of poisoning incidents between males (49.6%) and females (49.1%).

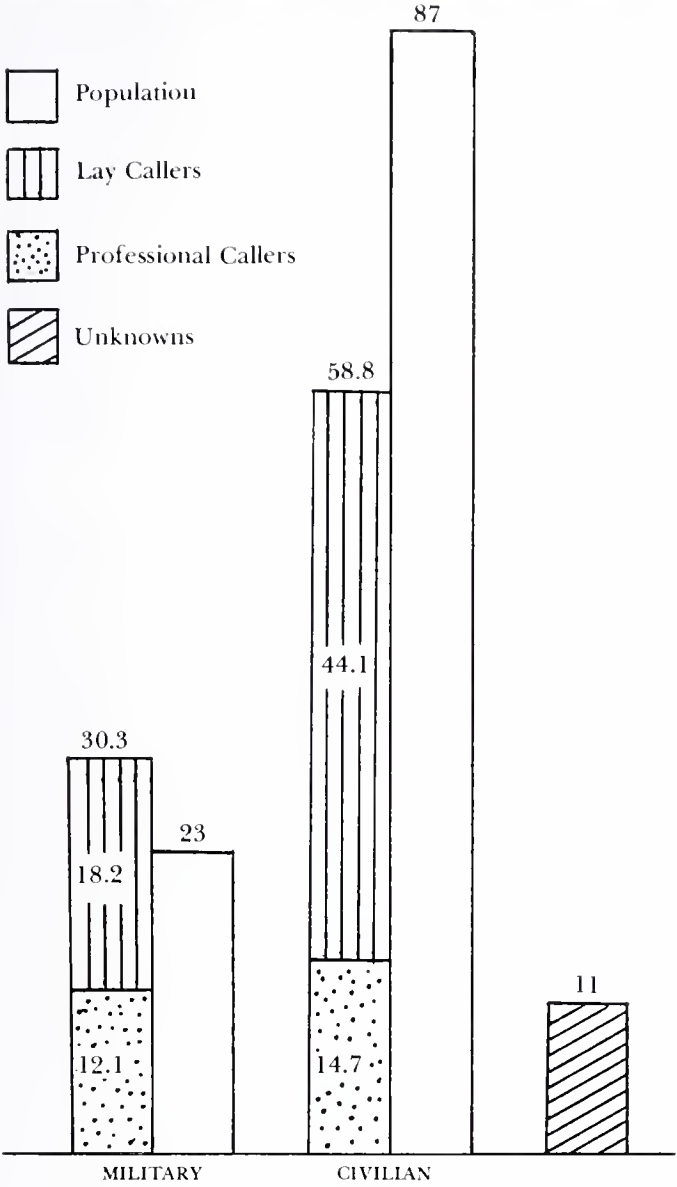
Figure 2 indicates that there is a disproportionately high number of poisoning incidents among military personnel, when compared with the civilian population. This is especially marked when calls from military and civilian professionals are compared. Although there are many more civilian than military professionals, their

TABLE 1.—Poisoning incidents by age.

AGE	NO	%	CUM. %	%/YR.
0-1	33	6.1	6.1	6.1
1-2	88	16.4	22.5	16.4
2-3	85	15.9	38.4	15.9
3-4	41	7.6	46.0	7.6
4-5	21	3.9	49.0	3.9
5-10	28	5.2	55.1	1.0
10-16	22	4.1	59.2	1.0
16-20	27	5.0	64.2	1.3
20+	164	30.5	94.7	—
Unk.	29	5.4	100.1	—
Total	538			



FIG. 2.—Percent of poisoning incidents in civilian and military categories compared to their proportion of the States population.<sup>3</sup>



respective proportions were 14.7% and 12.1%. Nearly half (44.1%) of the incidents involved civilian lay personnel.

Whether a caller is symptomatic or asymptomatic may be vaguely associated with the severity of the incident. However, the determination and description of symptoms as provided by the caller is highly subjective. From the sample, 43.3 percent of the victims were asymptomatic. Another area that may reflect the severity of a poisoning incident is follow-up. Personnel at the Center follow up all poisoning incidents except those from the neighbor islands and from professional callers. Of the 538 incidents, 386 (71.7%) callers were contacted. Of this number,

TABLE 2.—Route of contact.

ROUTE OF CONTACT	%
Ingestion	75.1
Sting/bite	6.0
Inhalation	5.8
Dermal	5.8
Eye	3.3
Combination	2.2
Unknown	1.9
Total	100.1

273 (70.7%) reported “that they felt O.K.”; 41 (10.6%) still had symptoms; and 82 (21.2%) were lost to follow-up.

Table 2 shows the route of contact with substances implicated in poisoning incidents. Most contacts (75.1%) were by ingestion. All other routes were of minimal proportions, with stings or bites second at only 6.0 percent.

TABLE 3.—Breakdown of substances identified in poisoning incidents

ITEM OR CATEGORY	No	%
Prescription Medications:		
Valium	5	1.0
Percodan	4	0.7
Others	59	10.9
Totals	68	12.6
Non-prescription Medications:		
Aspirin	12	2.2
Multivit Preparations	12	2.2
Acetaminophen	9	1.7
Ben Gay	5	1.0
Exlax	4	0.7
Nytol	4	0.7
Calamine	4	0.7
Others	59	11.5
Totals	109	20.3
Household Products:		
Adhesives	5	1.0
Art Supplies	5	1.0
Auto Supplies	3	0.6
Bleaches and Disinfectants	18	3.3
Cleaners	16	3.0
Cosmetics and Grooming	21	3.9
Deodorizers	4	0.7
Soaps and Detergents	22	4.1
Gasoline	11	2.0
Other Petroleum Distillates	22	4.1
Totals	127	23.6
Plants:		
Taro Leaves	7	1.3
Elephant Ears	5	1.0
Mushrooms	5	1.0
Pepper	5	1.0
Dieffenbachia	4	0.7
Others	39	7.2
Totals	65	12.1
Pesticides:		
Harris Roach Tablets	4	0.7
Johnson No Roach Trap	4	0.7
Mothballs	4	0.7
Others	46	8.7
Totals	58	10.8
Zoonotics:		
Bee	6	1.1
Portuguese-Man-of-War	5	1.0
Scorpion	4	0.7
Others	21	3.9
Totals	36	6.7
Miscellaneous Chemicals:		
Fertilizers	6	1.1
Others	22	4.1
Totals	28	5.2
Tainted Foods:	24	4.5
Unspecified Substances:	7	1.3
Unknowns:	16	3.0
Totals for all Substances	538	100.1

Most incidents (85.7%) were accidental; 52 (9.7%) were intentional, i.e., suicidal attempt or gesture. In 4.7 percent of the incidents, it was unknown whether it was accidental or intentional. Substances implicated in poisoning incidents are listed in Table 3. Specific products involved in 4 or more incidents are listed under the major categories. Medicines and household products accounted for over half (56.5%) of the incidents; 20.3 percent of these incidents involved "over the counter" products. Individual products of note were: aspirin, 2.2 percent; multivitamin preparations, 2.2 percent; gasoline, 2.0 percent; and acetaminophen, 1.7 percent.

TABLE 4.—*Distribution of incidents in the State compared to population.*<sup>2</sup>

Figure 3 shows the geographic distribution of incidents on Oahu according to telephone prefix. While these values do not represent rates and thus are not valuable for accurate comparisons between areas, gross observations can be made. There appears to be clustering on and near military installations: Schofield, 42; Tripler, 40, and KMAS, 24.

## Conclusion

FIG. 3.—*Geographic distribution of incidents on Oahu.*



are involved in most incidents.

The age group involved in the greatest number of incidents and the peak period of incidents would indicate that parental education is a most important preventive measure. Points to be stressed should include: 1) recognition of poisonous substances; 2) storage of all toxic products in original containers; 3) reading and using first aid measures on poisonous containers; 4) presence and use of syrup of ipecac in the home; and 5) telephone numbers of private physician and Hawaii Poison Center quickly

available, as well as use of 911.

### Acknowledgements

The cooperation of the Hawaii Poison Center and its director, Jane Kagihara, R.N., for access to this data was appreciated.

This study was supported by the Hawaii Epidemiological Studies Program, through a contract with the Human Effects Monitoring Branch, Technical Services division, Office of Pesticide Programs, U.S. Environmental Protection Agency, Washington, D.C. 20406.

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3. Ibid.



## Bite This Bullet

Once I bought a bottle of cheap aspirin tablets that were so hard to chew ("always chew it up and wash it down") that I poured them all into the toilet, resolving not to buy Brand X anymore. The following morning I was surprised to see that the tablets all remained in the bottom of the bowl, stony hard and undissolved!

The FDA had approved those little marbles as containing 300 mg of ASA, though I don't suppose they would ever be much help to your headache.

Some generic drugs *are* therapeutic equivalents and represent real value to the consumer. Others, like my aspirin and certain cardiac glycosides, prove worthless and occasionally lethal.

The concept of bioavailability remains a difficult thing to legislate. Because of bureaucratic inertia amid a rapidly changing marketplace, FDA "approvals" are, at best, wistful predictions based on retrospective analysis, in the same class as weather forecasts.

It will be important, under the coming legislation, to retain an easy ability to veto generic substitution. Prescription notations such as, "May substitute generic unless this box is checked," have proven best. Only physicians can know which medicines are likely to be safe and effective for their unique patients at a given moment.

On the other hand, we also have a responsibility to learn the facts: are good generic equivalents available for your ten commonest drugs? Check with your hospital pharmacist for cost-effectiveness, then your local drugstore for availability.

JMC

## A Bitter Pill

The young man at the pharmacy counter was raising a real fuss. He had just learned that a two-week supply of acne pills would cost him \$28.00!

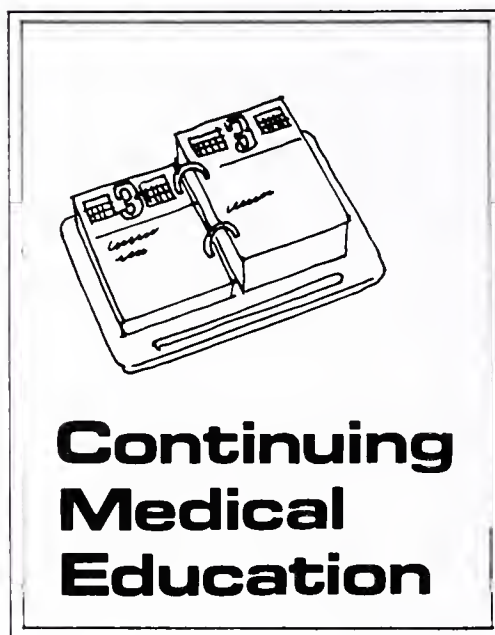
"Doctors all own stock in the drug companies," he told everyone within earshot. He went on to relate that his prescription (for the twice-a-day dose of a long-acting synthetic tetracycline) cost one dollar per pill!

It seemed that if his physician had been aware of the price, he might have prescribed an ordinary tetracycline at one-fourth the daily cost, or a generic brand at one-eighth the price.

In all the political argument over drug costs, one thing seems sure: physicians do not have clear ideas of the costs of their prescriptions. And we really owe it to ourselves and our patients to find out.

Try to estimate the cost of a week's supply of ten drugs you most commonly prescribe. Then have one of your staff check with a druggist. This usually proves a very enlightening exercise. Sometimes the cost-benefit ratio seems hard to swallow.

JMC



## CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

### LOCAL ACCREDITED PROGRAMS

#### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Third Tues. w/Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. Dept of Medicine
  - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
  - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.



- E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
- F. Infections Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
- G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
- H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
- 2. Division of Nuclear Medicine
  - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
  - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
- 3. Dept. of Obstetrics and Gynecology
  - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
- 4. Division of Orthopaedics
  - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
  - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
- 5. Dept. of Pediatrics
  - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
  - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
- 6. Dept. of Psychiatry
  - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
  - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room II).
- 7. Dept. of Surgery
  - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
  - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
  - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
  - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
- 8. Depart of Family Practice
  - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
  - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
- 9. Department of Physiology
  - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
- 10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
- 11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

#### Hawaii Thoracic Society

- 1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest

Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respcio, B.S.N. at (808) 537-5966.

#### Hickam Clinic

- 1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
- 2. Didactic—our staff, Second Thursday, 11:00 a.m.
- 3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
- 4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

#### Hilo Hospital

- 1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
- 2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
- 3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
- 4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
- 5. C.P.C., Fourth Friday, 12:30-1:30 p.m.
- 6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
- 7. Visiting Professor's Program
- 8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m. (Preventive Med.-Public Hlth. oriented.)

#### Kaiser Hospital

- 1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
- 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
- 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea mnth. 8:00 a.m. 1 hr. Cat. I.
- 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
- 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I. (Contact CME Dept.-Kaiser for further information)

#### Kapiolani-Children's Medical Center

- 1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
- 2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
- 3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
- 4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud. First—Didactic Presentation Second—Perinatal-Neonatal Topics Third—Obstetrics Topics Fourth—Gyn Topics
- 5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

#### Kuakini Medical Center

- 1. G.I. Conference, Third Tuesday, 8-9:00 a.m.
- 2. Nephrology Conf., Fourth Wednesday, 8-9:00 a.m.
- 3. Oncology Conf., every Thursday, 7:30-8:30 a.m.
- 4. Pulmonary Conf., Fourth Thursday, 1-2:00 p.m.
- 5. Surgical Conf., First, Second, Third Fridays, 12:45-1:45 p.m.
- 6. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
- 7. Ophthalmology Departmental Mtg., First Tuesday, 1-2:00 p.m.

#### Maui Memorial Hospital

- 1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm. 1st—Dept. of Medicine 2nd—Dept. of Surgery 3rd—Dept. of OB/GYN 4th—Dept. of Pediatrics 5th—Elective
- 2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—3rd Tues. 12:15-1:15 p.m.
- 3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
- 4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

### The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

### St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. Second Tues. ea mnth. 7:30 a.m. Sullivan 4-classroom.
4. Surgical Grnd. Rnds. Fridays (except Fourth), 7:30-8:30 a.m. Sullivan 4-classroom.
5. Surg. Mortality & Morbidity Conf. Fourth Fri., 7:30-8:30 a.m. Sullivan 4-Classroom.
6. Hematology Conf., Third Thurs. ea. mnth. 12:30-1:30 p.m. Sullivan 4-Classroom.
7. Renal Conf. First Monday ea. mnth. 7:30-8:30 a.m. Sullivan 4-Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.
9. Pulmonary Conf. Second and Fourth Wed. ea. mnth. 12:30-1:30 p.m., Sullivan 4-classroom.
10. Endocrinology Conf. last Monday ea. month 12:30-1:30 p.m. UH-4 Classroom.

### Straub Clinic & Hospital

1. Anesthesia Conference meets the Second Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the Fourth Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets First, Second and Third Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the Fourth Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the First Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.
6. Neuropathology Conference meets the Third Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the Fourth Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the First Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the Second Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the Second Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the Fourth Thursday of each month from 7:00-8:00 a.m. in the DDR.

### Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

### Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday

2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

### Miscellaneous

Hawaii Radiological Society meetings, Third Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, First Monday, 5:00 p.m. dinner meeting and Third Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: 1, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction

### SPECIAL EVENTS

- |                      |  |
|----------------------|--|
| Dec. 6-9, 1979       | American Medical Joggers Assn.<br>Mr. Hugh S. Ames<br>Honolulu Marathon Assn.<br>P.O. Box 27244<br>Chinatown Station<br>Honolulu, HI 96827<br>Hdq. Hotel: Princess Kaiulani                        |
| Jan. 6-13, 1980      | Ultrasound Conference, John A. Burns Schl of Med., co-sponsored by the Honolulu Medical Group, Research and Education Foundation, 18 Category 1 credit hours. Mauna Kea Beach Htl.                 |
| Jan. 6, 11, 1980     | Clinical Pharmacology for the Practitioner, The Am. Instit. of Postgrad. Ed. to be held at Maui Intercontinental Hotel. 21 hrs Cat. 1.   |
| Jan. 8-12, 1980      | Intensive Review of Common Allergic & Asthmatic Diseases, U of Cal., Davis, Schl. of Med. Intercontinental Htl., Maui.   |
| Jan. 12, 18, 1980    | Perinatal Medicine, USC. Held at Royal Lahaina, Maui. 20 hrs. Cat. 1.  |
| Jan. 14-18, 1980     | 15th International Surgical Congress (Ten Surgical Specialties) Sheraton Waikiki, 20 Category 1 credit hours, Pan Pacific Surgical Association.  |
| Jan. 14-20, 1980     | Estes Park Institute, Kauai Surf Htl., Ms. Tomi Wilson, Admin. Dir., P.O.Box 400, Englewood, CO 80110.   |
| Jan. 15, 22, 1980    | Iowa Lutheran Hsp. Med. Staff Postgraduate Seminar, Royal Lahaina, Maui.   |
| Jan. 19-21, 1980     | Common Obstetric and Gynecological Problems, co-sponsored by Tulane University School of Medicine, Department of Ob-Gyn, and Hawaii Section of ACOG, 15 Category 1 credit hours, 15 cognates ACOG. |
| Jan. 28, 31, 1980    | 19th Ohio St. Univ. Urological Outing Kauai Surf, 16 hrs. Cat. 1   |
| Jan. 26-Feb. 2, 1980 | Nephrology, USC, Princeville, Kauai.   |
| Feb. 1-4, 1980       | Hawaii Review, co-sponsored by the Hawaii Chapter of AAFP, with invitation to BC Chapter College of Family Physicians of Canada, and Section of General Practice, BC Medical Association.          |
| Feb. 4, 8, 1980      | Surgical Diagnosis & Therapy, Phil Thorek Postgraduate Courses, Maui.  |
| Feb. 10-17, 1980     | Otolaryngology Update, Hilton Hawaiian Village 10-14 & Kona Hilton, 14-17. U of C Dept. of Oto & Sacramento Soc. of Oto. Leslie Bernstein, M.D., D.D.S. P. O. Box 3213, El Macero, CA 95618.       |



- Feb. 16, 23, 1980 Postgraduate Course in Clinical Allergy, Maui Surf, 28 hrs. Cat. I. J.A. Burns Schl. of Med.
- Feb. 16, 23, 1980 Dilemmas in Obstetrics, U of Cal. San Fran. Held at Kauai Surf.
- Feb. 16, 23, 1980 Physicians' Program in Undersea Med., Undersea Medical Society.
- Feb. 21, 27, 1980 Professional Laboratory Management Institute, Am College of Pathologists, Sheraton Waikiki & Sheraton Maui.
- Feb. 23, Mar. 1, 1980 Intercontinental Conf. on Diagnostic Medicine, Ohio Acad. of Family Prac. Held on Maui.
- Mar. 1-8, 1980 American Urological Association, Western Section, King Kamehameha Hotel and the Sheraton Waikiki.
- Mar. 1, 8, 1980 Marquette-MCW Med Alumni Assoc. Clinical Conf. Held on Maui.
- Mar. 10, 15, 1980 Diagnostic Radiology including Ultrasound & CT Scanning, Duke Univ. Med Centr. Held at Hyatt Regency, Waikiki.
- Mar. 18-22, 1980 Sports Medicine, Department of Physiology, Princess Kaiulani, 18 Category 1 credit hours. J. A. Burns Schl. of Med. Contact: Harold Brown, Hawaii Conf. Serv. P. O. Box 25055, Honolulu 96825 (808) 377-6445.
- Mar. 19, 25, 1980 Traveling Medical Education Course, Penn. Med. Society. To be held at Kauai Surf.
- Mar. 27, Apr. 4, 1980 9th Obstetrical Anesthesia Conf. Ohio St. Univ. College of Med., Marina Del Rey, CA. To be held at Sheraton Waikiki.
- Mar. 29, Apr. 4, 1980 Infectious Disease Conf. U of Wash. Schl of Med. to be held at Ilikai Htl. 20 hrs. Cat. I.
- Mar. 31-Apr. 4, 1980 Current Concepts in Obstetrics and Gynecology, John A. Burns Schl of Med., co-sponsored by the University of Washington, Dept. of Ob-Gyn and Hawaii Section of ACOG, Ilikai Hotel, 24 Category 1 credit hours, 24 cognates ACOG.

\*\*\*\*

## OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



"I HATE TO WAKE HIM - HE HAD A RATHER RESTLESS NIGHT."



## Friday, September 7, 1979 HMA CONFERENCE ROOM

### PRESENT:

Drs. Goto, Bell, Winn, Hanlon, Chinn, Iaconetti, Chang, Azman, Miles, Cahill, McNamee, Howard, McCabe, Roth, Clingan, Fu, Wigle, Magoun, Mills, Dang, Simmons, Hellreich, Chung, Mrs. Nancy Simmons, and Mr. V. Thomas Rice. HMA Staff present were: Messrs. Won, Saranchock, Leineweber, Ajifu, Ontai, and Mmes. Kendro, Chang, and Wong.

### CALL TO ORDER:

The meeting was called to order by President Goto at 5:50 p.m.

### MINUTES:

The minutes of the previous meeting were approved with corrections.

### REPORT OF THE SECRETARY:

The Council reviewed the Report of the Secretary as of July 31, 1979 which indicated that HMA membership totaled 895 in comparison with July 1978 when membership totaled 890.

### REPORT OF THE TREASURER:

The June 1979 Financial Statement was reviewed in detail and approved subject to audit.

The primary focus of this meeting was to review in detail the 1980 Budget of the HMA as proposed by the Finance Committee.

#### ACTION:

**It was moved, seconded, and passed to recommend to the House of Delegates the 1980 HMA Budget as amended.**

### REPORTS OF COMMITTEES AND COMMISSIONS:

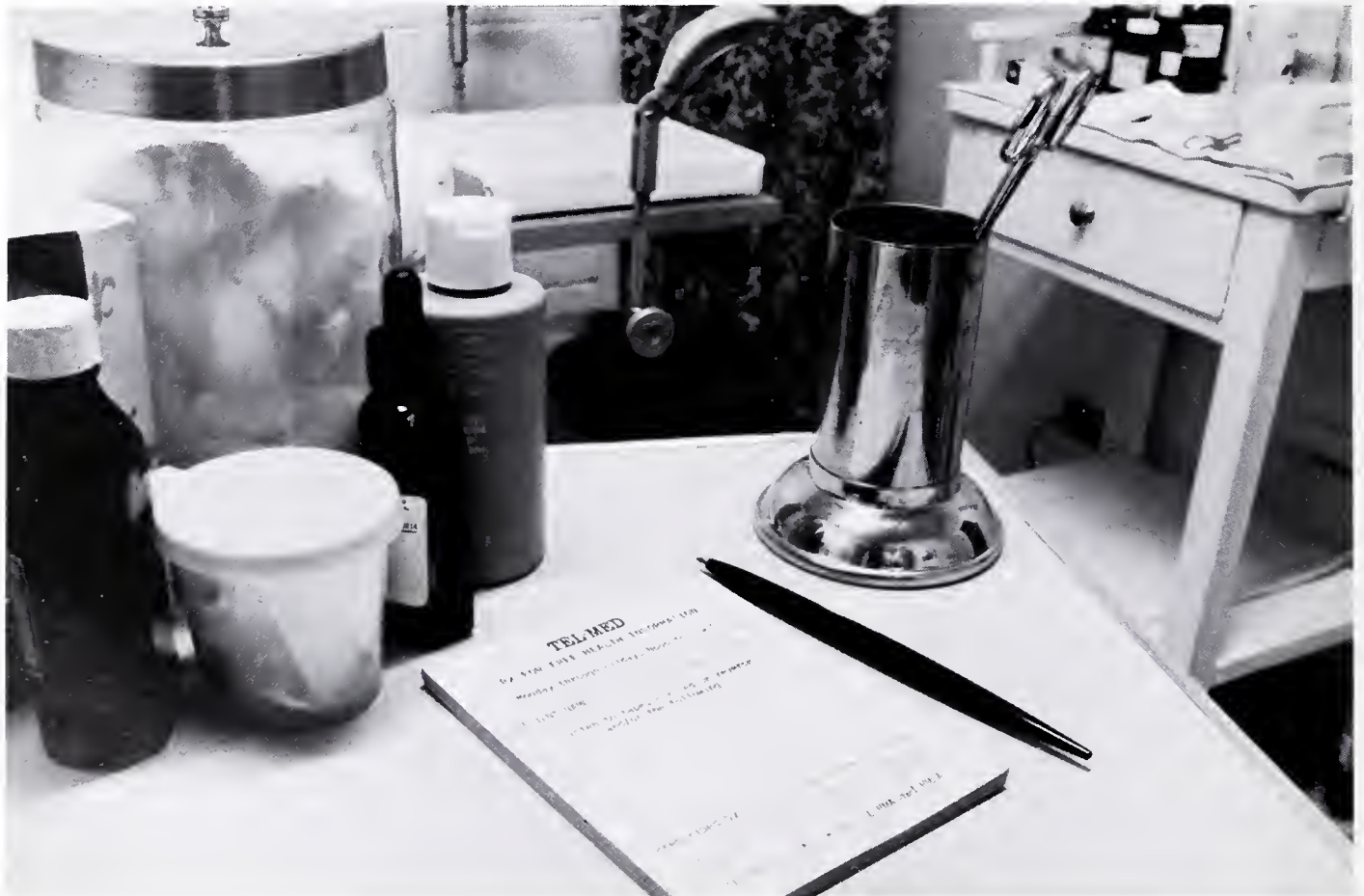
*A. Malpractice Law Committee:* Dr. Philip Hellreich briefed the Council on the activities of the Malpractice Law Committee and presented a sample resolution proposing a petition for a complete rate review hearing before the Hawaii Insurance Commission.

#### ACTION:

**The Council commended the Malpractice Law Committee for the work it's done. It was moved,**

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**seconded, and passed to refer the resolution to the House of Delegates.**

*B. Ad Hoc Committee on Computers:* Mr. Jon Won reported that the Committee has conducted an analysis of proposals submitted by various computer vendors. Computer systems offered by these companies were ranked according to cost, continuing support, and ease of customizing reports. The Committee recommended that HMA pursue negotiations with IDS for the purchase of a computer.

**ACTION:**

**It was moved, seconded, and passed that HMA pursue with negotiations for the purchase of a computer.**

It was agreed that the 1980 Budget be modified to include financing for the computer.

*C. AMA Delegate:* Dr. Herbert Chinn gave the Council an overview of the proceedings of the AMA House of Delegates which met in July 1979. Discussed at the AMA Meeting were medical ethics, national health insurance, LCCME, chiropractic, membership recruitment, guidelines for coronary bypass surgery, etc.

A suggestion was made by Dr. Chinn to establish a Program Committee to take care of social functions for the various medical groups visiting in Honolulu. As an activity of the proposed committee, it was recommended that HMA hold a "Fun Night in Hawaii" on December 4, 1979 at the Empress Restaurant.

**ACTION:**

**It was moved, seconded, and passed to (1) establish a Program Committee and (2) hold the "Fun Night in Hawaii" on December 4, 1979, with the funds used to cover Hiroshima entertainment expenses, California delegation entertainment expenses, and for Dr. George Mills' candidacy for the AMA Board of Trustees and presidency if he runs.**

*D. Ad Hoc Committee on Cancer Center:* The Council reviewed a revised draft position statement on the Cancer Center of Hawaii.

**ACTION:**

**It was moved, seconded, and passed to adopt the HMA position statement on the Cancer Center of Hawaii as amended. There was one opposing vote.**

*E. Internal Affairs:* With regard to the Annual Meeting, Dr. Neal Winn reported that 39 of the 40 exhibit spaces have been reserved to date. Dr. Winn also reviewed the schedule for the House of Delegates sessions, sports and social events.

*F. School Health:* On behalf of Dr. Ann Ho Yee, Mrs. Kendro reported that the School Health Committee is requesting that HMA support a prospective study on kindergarten children, relating to learning problems, to be conducted by Dr. Larry Frisch, Medical Director of the Child Protective Services.

**ACTION:**

**It was moved, seconded, and passed that the HMA support the study relating to learning problems.**

*G. EMS:* Dr. William Dang brought the Council up to date on the status of the EMS Program. Dr. Dang reported that a meeting was held with the DOH representatives on August 31 to discuss the future relationship of the HMA-EMS Program with the State DOH.

Most recently, the DOH has requested the EMS Program to do uniform training throughout the State, with a FY 1980-81 budget to be submitted. The EMS Program is also considering the submission of a grant request to DHEW for funds to conduct training on the neighbor islands. The Council was requested to approve funds of up to \$500 for the EMS graduation on September 28.

**ACTION:**

**It was moved, seconded, and passed (1) that HMA accept the offer of the State DOH to do statewide training; and (2) to approve the expenditure of up to \$500 for the EMS graduation.**

*H. Health Service and Care:* Mrs. Becky Kendro reported that Dr. George Bolian has accepted the chairmanship of SHPDA's Health Manpower Task Force. In addition, Dr. Donald Char (Commissioner, Health Service and Care) has accepted the chairmanship of a committee to review the Health Section of the State Master Plan; the review was ordered by the Legislature. It was noted that there are three physicians serving on this committee.

A suggestion was made by Dr. Chinn for HMA to conduct a study on physician manpower in Hawaii, perhaps through the specialty societies.

**ACTION:**

**It was moved, seconded, and passed to conduct a study on physician manpower in the State.**

*I. Building:* Mr. Andrew Saranchock reported that the Building Committee met just prior to the Council to consider the 1980 Building Budget. The proposed



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budget was submitted to the Council for its consideration.

**ACTION:**

**It was moved, seconded, and passed to recommend the 1980 Building Budget, as submitted, to the House of Delegates.**

*J. Health Fair:* Mr. Jon Won reported that Health Fair Chairman, Dr. Charlotte Florine, is currently on the mainland researching the experience of other health fairs. HMA's Health Fair is tentatively scheduled for September 22-28, 1981.

**REPORTS OF COUNTY SOCIETY PRESIDENTS:**

*A. Honolulu:* Dr. Walter Chang reported that the Society's last dinner meeting was held on September 4 at the Hawaiian Regent Hotel with guest speaker, Mrs. Betty Sullivan. On October 23, a program on HMSA has been planned. The HCMS Annual Meeting and installation of officers will be held on December 2, 1979 at the Honolulu International Country Club.

*B. Maui:* Dr. Ben Azman reported that the Society met on August 21 with Congressman Cec Heftel as the featured speaker. The Society will hold its next meeting on September 18 with Dr. Charles Mitchell to speak on pre-hospital emergency care and EMS operations on Maui.

*C. Hawaii:* Dr. A. Scott Miles reported that the

Society will hold its next meeting on either the third or fourth Friday of this month. The meeting will focus on the subject of infectious diseases. It was also reported that the Hawaii Society is forming an impaired physician committee. Dr. Miles thanked the Council for making it possible for him to attend the AMA Annual Meeting in Chicago.

*D. Kauai:* Mrs. Becky Kendro reported that she had the honor of addressing the Society at its meeting of September 6 on national and local issues.

**OTHER BUSINESS:**

*A. Auxiliary:* Mrs. Simmons reported that she and Mrs. Edith Don attended the National Auxiliary's Annual Meeting which was held in conjunction with the AMA's Annual Meeting. Mrs. Simmons commented that the national Auxiliary's theme for the next two years will be "Shape Up for Life."

*B. Hiroshima Prefectural Medical Association:* Mr. Jon Won reported that the Board of Directors of the Hiroshima Prefectural Medical Association will visit Hawaii from December 31, 1979 to January 7, 1980. A committee has been organized to plan a joint scientific session and to suggest ways in which HMA can express its hospitality.

**NEW BUSINESS:**

*A. AMA Awards:* Dr. George Mills reported that the AMA has invited HMA to submit nominations for

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its major annual awards. The nominations will be considered by the AMA Board of Trustees.

*B. Aces and Deuces:* Dr. George Mills recommended that HMA continue its membership in the Aces and Deuces organization.

**ACTION:**

**It was moved, seconded, and passed to approve the expenditure of \$75 for HMA to continue its membership in the Aces and Deuces.**

*C. UH School of Public Health Class:* Mr. Jon Won reported that HMA will be participating in an assignment of a UH School of Public Health class, which is studying the operations of various health related organizations. Students will be attending certain committee meetings and interviewing some of the leadership.

*D. Vote of Thanks:* Members of the Council commended Dr. George Goto for his leadership during the past year as HMA President.

**ADJOURNMENT:**

The meeting was adjourned at 11:10 p.m.



**Anthony K. C. Chiu, M.D.**

1314 South King Street  
Honolulu, Hawaii 96814

INTERNAL MEDICINE  
GASTROENTEROLOGY



**Charles H. Yamashiro, M.D.**

2230 Liliha Street  
Honolulu, Hawaii 96817

RADIATION THERAPY



## Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

**New Members—None.**

**Members Dropped—Judith Hartner**, active member, has announced her relocation to Arizona.

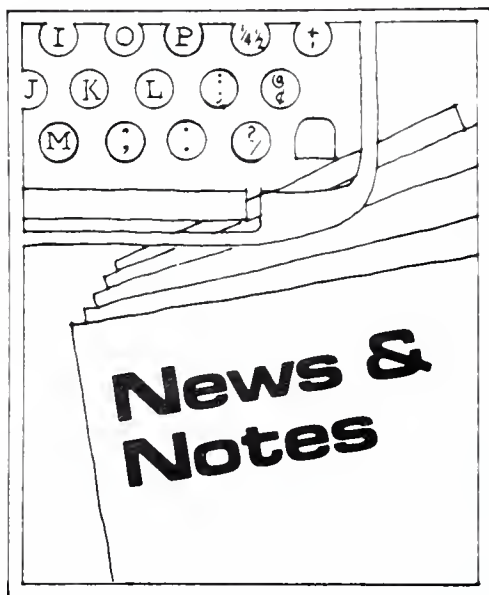
**News of Members—Tom Cahill's** name was submitted by the Council to be considered by the Board of Directors of AAFP for a seat on the Health Services Committee and **Don Farrell's** for a post with the Education Committee. **Doris Jasinski**, as Chief of the Department of Family Practice at Kapiolani-Children's, has announced a meeting of that department every 4th Wednesday at 1:00 PM. **Jim Tsuji** will represent us on the Better Health Network (IBF) workshops in May next year. **Tom Cahill's** picture came out quite clearly as he waited in line to speak at a reference committee on CME requirements at the Atlanta Congress of Delegates, although he was not named in the REPORTER 3 issue of 10 October. **Tom** and **Don Farrell** as delegates, **Jim Tsuji** as alternate delegate, represented us at the Congress. So far, ye editor has no word as to who else from Hawaii attended the Scientific Session, to which 3,523 physicians were registered.

**Credit Hours—**there was a major revision that came out of the 1979 Congress: 1) What used to be "E" or Elective will henceforth be designated "PI" or Personal Interest hours (how much more confusing can we get ?/Ed) but the good news is that all Category 1 of the AMA or LCCME will be automatically "PI" for us *without prior approval* by AAFP being required; 2) if the sponsor receives prior approval from AAFP, many of these good programs can be awarded "P" category; 3) formal scientific meetings offered by hospitals, if prior approval has been obtained, may qualify for "P." As I read the new Reprint #101, there is no longer the requirement that approval for "P" is predicated upon participation by members of AAFP in the program planning; however, in a personal communication from the secretary of the AAFP Committee on CME, there is some question about this. At least we now know that the program of the Pan-Pacific Surgical Ass'n 15th Congress, 12-18 January 1980, will be "PI" for us.

**CME Reminders—**The Minnesota AFP is hosting a seminar on Maui, 20-29 Jan 80. Don't forget to sign up now with a \$25 down payment for "Hawaii Review" on 1-4 Feb 80. Full registration fee is \$150 prior to December; after that it will be \$165 (34 hours of "P"

over 4 days). The "Pheresis" program 15, 16 November was listed as 6 hours of Category 1, which means that under the new rules of the AAFP it counts for 6 of "PI" (old Elective).

**Cancer Control**—The tumor reporting to AAFP, in which many of us participated, is terminated (funds ran out). "Cancer Guidelines" is being offered instead.



HENRY N. YOKOYAMA, M.D.

## Life In These Parts

On Sunday morning, we turned into the KMC doctor's parking lot and ahead of us sputtered an antique convertible with shiny chromed dual exhausts and a new coat of paint . . . We wondered about the nondescript resident who must own the hot rod when to our amazement, out popped our nephrologist friend **Dudley Seto** who usually drives a Jaguar . . . **Francis Oda** asked if the car was his son's and Dudley was indignant: "It's my own '65 Chevy Impala convertible, a classic." We learned that he had purchased it for \$1,500, and has already been offered \$3,000. It is worth twice that figure on the West coast. One of his fleet of 12 classics, we learned . . .

Our favorite vitamin-tuna man, **Nobu Nakasone**, was found comatose one Monday night last month in the KMC surgery doctor's waiting room . . . Two hours earlier, he had expounded his regimen for longevity to vascular surgeon **Harvey Takaki** . . . Nobu regained consciousness from his cerebral bleed in ICU, and was later transferred to Straub where the culprit, an aneurysm of his anterior communicating, was successfully clipped by Straub neurosurgeon **Bill Hammon** . . . How can anyone be so darn lucky? We are more convinced now than ever before that "A Coral Brand tuna a day keeps the doctor alive . . ." (To coin a pun . . .)

Straub dermatologist **Robert Kim** reported in JAMA that 45 persons in the first six months of 1978 had a type of fish poisoning from eating mahimahi. Symptoms included facial flushing, GI upset, headache, nausea and general discomfort . . . Bob relates the condition to toxin formed in the dark meat portion of tuna, mackerel and mahimahi when not properly refrigerated. Most of the cases were traced to frozen mahimahi from Taiwan . . .

The state Attorney General's Medicaid Fraud Control Unit created last year feels that the practice of overbilling by Medicaid providers is widespread in the Islands. Rich Eichor, deputy attorney general heading the fraud control unit reported that "In just one provider group (re, pharmacies) it is our belief that as much as \$200,000 of additional funds have been improperly obtained from the Medicaid program over the last three years through price discrimination by approximately 10 members of this provider group. If the total population of the provider group were considered, the dollar amount could rise substantially." Since the unit was formed, 31 investigations were begun and 13 closed. Ten of the 13 closed cases resulted in no action. The remaining cases thus far have yielded convictions for four persons for first degree theft. The unit has recovered about \$40,000 in Medicaid funds and has caught providers who have taken a total of \$50,000 to \$60,000 from the program each year.

The trouble is that everyone's a doctor. On Oct. 24 *Maui News* reported: "A Honolulu doctor became the first psychologist in the state to be found guilty of Medicaid Fraud." (How easily the physician can be maligned.)

With **Fred Gilbert** as project director, the Straub Clinic has launched a study of osteoporosis and its possible benefit from a vitamin D derivative . . . The project initially funded for two years by Upjohn is looking for 200 post-menopausal women not now taking estrogen, to volunteer in the double blind study. The women have to be 1 year and no longer than 10 years post-menopausal; must not have any symptoms of osteoporosis and must not be taking thyroid, cortisone, tranquilizers, arthritis treatments, flourides or supplemental vitamin D.

The Honolulu Medical Group Research and Education Foundation hosted a one day conference in October on "Prescription Drug Misuse" aimed at the professional community. **Richard Littenberg**, medical director of the Medical Group says, "The abuse of drugs is really an artificial adaptation to today's world. This dependence on chemicals to combat increasing stresses should be curtailed . . . Otherwise, who knows what it will take to adapt to problems in tomorrow's world. Drug abuse and misuse is an individual affair where the practitioner is caught in a bind. Short term use of these drug agents is justified where an end to the treatment is in sight. But when there is chronic use or open ended treatment, this presents a real problem. Physicians need to think more about alternatives to drugs . . ."

A congressional report this spring claimed that some 2 million unnecessary surgeries were performed in a single year. But HMSA figures show that for the seven most common types of surgery, our rates are lower than mainland rates.

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The surgeries studied were tonsillectomies, appendectomies, cholecystectomies, herniorrhaphies, D & C's and hysterectomies. All seven of these surgeries have in fact declined in frequency locally from 1973 to 1977. PacPSRO president **Winfred Lee** says, "What should be realized is that for years before the government stepped in to tell us we should be doing it, Hawaii doctors have had committees in the hospitals to look at deaths and analyze why they occur. Still, even in Hawaii, the need for surgery or the manner in which it is performed sometimes does come under question . . . Like any other profession, the medical profession has its imperfections." PacPSRO quality assurance director **Henry Oyama** commenting on hysterectomies and tonsillectomies says, "These two procedures are not the top two operations done here. In fact, tonsillectomies, long discouraged by pediatricians as usually unneeded, wouldn't even make the top 20." OB Gyn man and post HMA president **George Goto** commented that though the congressional report claims that hysterectomies too often are performed for birth control purposes or to prevent potential uterine cancer, this was uncommon in Hawaii . . . Herein are some HMSA statistics: On per capita basis, tonsillectomies on the Mainland in 1977 were eight times more frequent than here; hysterectomies on the Mainland were twice as frequent . . .

AMA president **Hoyt Gardner** here for the Annual HMA Meeting feels that Congress isn't likely to pass a national health insurance law at this time because of the inflationary period. The several proposals before Congress for national health insurance could cost the taxpayer from \$40 to \$100 billion annually and could double in five years. "Look at what has happened with Medicare and Medicaid. Medicare costs doubled within five years and so, in one way or another, did taxes . . . The proposals talk about free health care, but in no way is health care in this country going to be free. Somebody is going to have to pay for it."

The Hawaii Fire Fighters Association which had tried unsuccessfully to establish more positions for non-fire emergency service and increased salaries for firefighters who also undergo training to win EMT and MICT ratings, has informed Hawaii County officials that its members will refuse to do emergency medical service work or conduct search and rescue operations on the Big Island as of the end of this year. (Ed. Such a waste of funds and training.)

Despite the UPW strike, Hilo Hospital is apparently maintaining its level of care according to Chief of Staff **Robert Irvine**. Nurses are doing kitchen duties following their normal work shifts and medical workers are cleaning up spills and collecting the garbage. Food service is slow but adequate with families helping feed the patients. And doctors are admitting only emergency cases.

Honolulu dermatologist **Norman Goldstein** who has done research on PABA says, "There's nothing you can do about the wrinkles you already have, but you can prevent future ones. I tell my patients to sun, surf, sail and play tennis—but every single day to use a sun protector. Men can mix it in their after shave." Norman advises: "Eat, drink and enjoy life in moderation . . . But watch out for that sun."

## Miscellany

A tall robust immaculately dressed young man sauntered down the street, swinging a shoulder strap purse and chanting, "Twenty-one today . . . Twenty-one today . . ." A huge burly roughneck observed the strange antics of the young man and turned to his fellow workers, "My God! He must be one of those blokes! I'm going to have a little fun with this bum!" So he approaches the young man and yells "Hey there! Let's see what you have in that purse!" The young man drops the purse, steps up to the burly intruder and with one powerful blow, lays him flat . . . Then he calmly picks up his purse, starts swinging it and begins to chant, "Twenty-two today . . . Twenty-two today . . ." as he goes his way . . . (As told to Cora Au, by her Scotsman friend Jim)

A repentant young man joins the monastery and takes the vow of silence. The head monk instructs him, "You may speak two words every 10 years." So he toils away with his monkly duties for the first 10 years and the head monk summons him, "You may now say your two words." The fellow says, "Food cold!" Then goes on with his duties . . . Another 10 years lapses and the head monk says, "You may now say your two precious words." The fellow says "Bed cold!" and shuffles on to do his monkly chores. The third 10 years pass. "What are your two words?" asks the head monk. The fellow says, "I quit!" The head monk says, "Somehow I always had the feeling you weren't cut out for this monastery." (As told to **Frank Fukunaga** by our real estate appraiser friend Walter Loo . . .)

## Professional Moves

We recall with nostalgia those days when all physicians had at least a nodding acquaintance with each other, but nowadays with the rapid influx of new physicians and with so many refusing to join the societies, we can attend a meeting and scarce recognize half the audience . . .

Well on with the shuffle . . . starting with the large groups. In September, Kaiser-Permanente added internist-endocrinologist **Siang-Yong Tan**; internist **Jonathan Cho**; ENT man **Fredrick Fiber**; hematologist-oncologist **John R. Mueh**; and OB Gyn man **Letah Yang**. The Honolulu Medical group added cardiovascular and thoracic surgeon **Michael Dang** and dermatologist **Kim Goh**. On the Big Island, the Hilo Medical Group added FP **Kevin Deginder** and on Maui, the Maui Medical Group added OB Gyn man **Robert Yapp, Jr.**, internist **William Mitchell**, and radiologist **Robert Bjornson**. Back in Honolulu, urologist **Clarence Hodges** joined **Andrew Morgan** at Queen's Physicians' Office Bldg; **Richard You** resumed his practice in general and sports medicine at 1270 Queen Emma St; psychiatrist **Leonard Jacobs** resumed his practice at the Kailua Medical Professional Ctr Bldg; dermatologist **William Wong** opened his branch office at the American Security Bank Bldg; psychiatrist **Emily Khaw** opened at 1164 Bishop St; pediatrician **P.K. Ng** opened at 1365 Nuuanu Ave, when old timer **Francis Chu**

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retired; **W. H. Wilkinson** relocated at 302 California Avenue; **Birendra Singh Huja** relocated to Aiea Medical Building, and dermatologist **Bruce Chrisman** relocated to 1319 Punahou Street . . . On Maui, D.O. **W.A. MacDonald** joined D.O. **James Baum** at the Wailuku Townhouse Building; ENT man **Andrew Don** relocated to 53 Puunene Avenue; Kahului and FP's **John Lewin** and **Edward Underwood** joined **Kenneth Haling** at 31 Kam Ave, Kahului . . . In West Hawaii, **Carlo Brizzolara** moved to the Kuakini Tower Bldg . . . On the Garden Island, FP **Robert Overlock** joined the Waimea Clinic and will head the Hyperbaric Medicine Dept at the Kauai Vet Memorial Hospital.

In October, internist **Anne Brennan** joined The Honolulu Medical Group; eye man **Geoffrey Davis** and Gynecologist **Shanon Chang Eaton** opened their office at 99-128 Aiea Heights Dr; nephrologist **David Yuan** relocated to the Kuakini Medical Plaza; OB Gyn man **William Fong** moved into Suite 990 Kapiolani-Children's Medical Center; and FP **E. Fred Schroeder, Jr.** joined The Haleiwa Family Medical Center. General and cardiovascular surgeon **Nathaniel Ching** resumed his practice at 181 S Kukui St. On Maui, pediatrician **William Kepler** relocated to The Maui Clinic in Kahului, Maui and in West Hawaii, **Bernard Fogel** moved to Kuakini Professional Plaza . . .

## Elected, Appointed, Honored

We offer our congratulations to **Cal Sia** named Physician of the Year for his tireless efforts as an advocate of child protective care viz his role in the Variety Club School, the Hawaii School for the Deaf and Blind, for spearheading the state laws which ensure a statewide school health system and the reporting of child abuse, etc, etc . . . We also thank our outgoing HMA president **George Goto** for his amazingly productive tenure during the past year . . . while recovering from an MI and a subsequent by-pass surgery, he still managed to carry on an active private practice . . . How George continued to smile and function in his quiet way is simply

beyond belief . . . We wish the best of luck to our newly elected HMA officers . . . viz president **Douglas Bell II**; president-elect **Neal Winn**; secretary **K.Y. Lum**; and treasurer **William Hindle**.

Cardiologist **Morton Berk** was awarded the Award of Merit for outstanding service to the American Heart Association "in recognition of dedicated and distinguished service in advancing the AHA national program designed to reduce premature death and disability from the diseases of the heart and circulation." The Maui Unit American Cancer Society installed **Russell Stodd** president, and **John Withers** vice president . . . New board members included **David Kosnick**, and **Michael Savona** . . . The Hawaii Medical Library elected **John Watson** president . . . Other officers included **Charles Judd** and **Ernest Scheerer** . . . Board members included **Charles Barnes**, **Nadine Bruce**, **John Watson**, **John Wellington**, and **Henry Yokoyama** . . . **Richard Littenberg** was named medical director of the Honolulu Medical Group . . . **Jack Keenan** is president of the Hawaii Rugby Football Union . . . **Richard Kelley** was elected to the Punahou School Board of Trustees . . . **John S. Smith** board chairman for the Honolulu Medical Group, was installed president of the Western Orthopedic Association . . .

## Fuelish Myths

(From the Sept. 17 issue of *Time*)

For the benefit of those economy minded drivers who may have missed the following items of interest, we have extracted the following:  
True or False?

1. Driving with the air conditioner turned on always wastes gas. False. Efficient air conditioners found in late model cars can save gas since, at speeds of 40 mph or more, the wind drag from open windows burns more fuel than does the cooling.
2. Slowly accelerating to cruising speed saves gas. False. Jack-rabbit starts do waste gas, but the quicker the car reaches cruising speed, the better the overall fuel mileage. The optimum fuel consumption comes between 40 and 50 mph.
3. It takes more gas to start a car than it does to let the engine idle for a few minutes. False. Letting a car idle for much more than 60 seconds consumes more gas than restarting it.
4. A warm engine is most efficient, so heat it up well before driving. False. Warm engines do work best, but running up an engine for a few minutes does no good, since it takes 20 minutes to reach maximum efficiency. Better to just let the engine tick over 30 seconds or so and drive off, warming up on the way.

Other hints on gas saving: When driving at 40 mph or more into the wind, slow down; the air resistance is costly. Do not increase speed when going up hills. Remove unnecessary weight from the car; lightening it by 100 lbs will produce an extra one half mile per gallon. Short trips are fuel wasters. Drives of five miles or less account for about 15% of the mileage on US cars, but consume over 30% of the gasoline. Reason: the trip is over before the engine begins to operate at peak efficiency.

## Sportsmen

Final Standing HMA Singles Tournament 1979 (**Kenneth Kern** chairman)

1. **Gerard Dericks**, 2. **Worldster Lee**, 3. **Ken Kern**, 4. **Ben Chang**, 5. **Gene Doo** and **Dennis Maehara** (tied), 7. **Bert Baysa** and **Mark Szasz** (tied), 9. **Frank Lu**, 10. **Gerald Mayfield**, 11. **Lawrence Gordon**, 12. **Niall Scully**, 13. **David Des Jarlais**, 14. **Gilbert Yamamoto**, 15. **Steven Berman** and **Liebert Fernandez** (tied), 17. **Yutaka Yoshida**, 18. **Howard Liljestrang**, 19. **H. Wm Goebert** and **Charles Ching** (tied), 21. **Victor Dizon**, 22. **Donald Peroff**, 23. **Robert Simmons**, 24. **James Bennett**, 25. **Norman Goldstein**.

Winner of Senior's Division (over 50): **Lawrence Gordon**  
Biggest surprise in the tournament: **Worldster Lee** upsetting **Ben Chang** after coming back from 0-5 in the 3rd set  
There has been considerable interest in establishing a



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tennis ladder for both singles and doubles so we will use this year's results and hope to have the ladder published each month in the HMA Journal. The only rule for the ladder is that if the player or team you challenge won't play you within one month, they will default. The challengers should supply the balls. The games can be played at whatever court agreed upon.

## Visiting Physicians

Endocrinologist Robert Neilson, clinical professor of medicine, Univ of Washington and one of the principal investigators of the UGDP Study lectured at a QMC Friday am conference on "Management Decisions in Diabetes and Common Problems in Diabetic Management." Herein are random notes therefrom:

"There is no neat little package for the management of diabetes mellitus . . . In all medical management . . . we take action from data . . . The goals of management are 1) prevention (for which we have no data) 2) cure . . . (not much in the way of cure) 3) control symptoms . . . (we can cure symptoms) . . . 4) prevent complications . . . (for acute, perhaps . . . for chronic, we don't know . . .)

Re, UGDP Studies: The UGDP Studies either concludes that treatment has no influence on vascular complications . . . or it tells us we should start treatment earlier . . . Most of us decide to treat once we diagnose diabetes . . .

Re GTT: GTT, the classic diagnostic tool, is now in disrepute . . . Among the six endocrinologists in our clinic, we may do 6 GTT's per year . . . I depend on random and repeat blood sugars . . .

How vigorously should we treat diabetes? Should we make the condition less abnormal or cure the abnormal? . . . "Try to treat patient to be as little abnormal as possible," i.e., "As close to normal as possible."

Re, Modality of treatment?: Diet is still the foundation of all modalities . . . viz provide adequate number of calories . . . restrict carbohydrates to 45 to 50% . . . The Absolute Must of diabetes diet is: "Same Amount; Same Time, Day In and Day Out."

Oral Agents: a) All oral agents can make blood sugar more normal, but carry certain risks . . . eg, Tolbutamide does not itself cause coronary artery disease, but causes more such deaths b) with oral agents, we can deviate from schedule without as much risk as insulin c) oral agents are convenient . . . "There is a place in our armamentarium for oral agents and I continue to use oral agents." esp on a) patients who cannot be controlled on diet alone and b) those patients who cannot tolerate insulin . . .

Insulin Therapy: a) Brittle diabetics (simply means lousy control . . . They are patients impossible to manage . . . In my 20 years, only a few are true brittle diabetics . . . ) b) 1 or 2 doses/d or mixtures? . . . Despite the enthusiasm for multiple dose insulin, there is no conclusive data that there is any advantage or improved results . . . Presently I prefer patients on single dose NPH or NPH and Lente before breakfast . . .

Brittle Diabetics: Three basic problems a) Too much insulin (the commonest cause) . . . These patients chase their urine sugars with extra insulin eg, sliding scale in the hospital) . . . b) Lousy injection technique and c) Lousy diet . . .

"As my old professor used to say . . . 'I've told you more than I know.'"

"I come here today not to praise UGDP, nor to bury it." Cas Jasinski asked what he meant by "Random Blood Sugars" and he got the following nebulous answer . . . "Any time that I can catch a patient . . . Usually plus or minus 2 hours post prandial or fasting sugars. Values greater than 200mg are diabetic . . . Less than 140 are not diabetics . . . We use the GTT to exclude the diagnosis of DM esp in pregnancy where rigid control of blood sugars is mandatory . . .

Someone asked what oral agent he used . . . "I personally use Acetohexamide . . . It has an abuse like effect and no antidiuretic effect . . . As you know there are only four oral diabetic agents left on the market . . .

"Glycosalated Hb levels correlate with blood sugars . . . but they have no role in clinical medicine unless you want to be a detective . . ."

We later asked our endocrinologist friend **Werner Schroffner** if he used antiplatelet aggregation factors and he replied, "The eye men do." "Do you?" "No."

## Oncology Dialogue

A 76-year old oriental woman in frail health had cysto for hematuria. The urologist found a 1 cm tumor on the Rt posterior wall, 3 to 4 cm from the ureteral orifice . . . He biopsied the tumor and fulgurated to the muscularis layer. No further procedures were planned because of her advanced age and frailty . . .

Pathologist **Grant Stemmerman** tried to stir things a bit: "She is 2 years short of the median age for Japanese women in this community . . . 'Faint heart may lose fair maid.'" Radiologist **Carl Boyer** asked, "Why don't you operate on her?" Grant: "Maybe he would let me." Urologist Tom: "But then again 76 is pretty old." Moderator **Quint Uy** was philosophical: "What makes 76 so bad?" Urologist **John Edwards** rose to defend his fellow urologist's decision: "If she were a young patient, you would shoot your wad . . . but at 76 . . ." Quint turned to Stemmy, the instigator: "Guess you're outvoted."



A 76-year old woman had a breast lump which showed up beautifully on gallium scan . . . Pathologist **Takushi Hayashi** showed his precious electron microscopic slides and described the specimen as a malignant lymphoma. He commented, "If we didn't know where it came from, we would be tempted to even call it a Burkett's Lymphoma . . . My teacher used to say, 'If I had one cell, I can tell malignancy, but with two cells, I cannot.'" Oncologist **Kevin Loh** stated, "Local radiation is indicated in this case . . . If it was Stage 3 or 4, then chemotherapy." Moderator **Quint Uy** asked, "Would you use lymphangiograms or CAT scans to stage?" Kevin: "A posterior lymphangiogram will be more helpful. Retroperitoneal

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node evaluation by CAT scan is still under study."

Radiotherapist **Carl Boyer** was stunned, "It's usually very difficult for me to agree with Kevin, but what can I say?"

A 58-year old man had a left nephrectomy and local radiation for hypernephroma in 1975. He was asymptomatic until recently, when while playing golf, he felt his back snap, and had to be hospitalized . . . Bone scans showed metastatic lesions of his spine, pelvis and long bones. The case was being presented as a long term survival of hypernephroma . . . At moderator **Quint Uy's** prodding, oncologist **Kevin Loh** stated, "Systematically, there is nothing promising . . . Dr Johnson at MD Anderson embolizes the kidney, then removes it surgically 24 hours later and has a 20% increase in survival." Radiologist **Ed Quinlan** reported, "I know of a patient who would periodically go to Memorial for surgical removal of metastatic lesions and got relief from pain." **Glenn Kokame** was curious, "Why is there such a high incidence of spontaneous remission of melanomas and hypernephromas?" Pathologist **Grant Stemmerman** replied, "I don't know . . . But of the two, hypernephroma is first and melanoma is second."

## Miscellany

(Sent to C.A. by her Scots friend Jim)

The Year is 1995 and the British Government's Policy of Socialized Medicine has now extended to include proxy fathers. That is—any married woman not having a child in the first five years of marriage must receive the services of a Government Man who will make her a mother . . . The Smiths have no children and the Government Man is due . . . Mr. Smith leaves for work and he has a hangdog look as he pecks his wife's cheek. "I'm off, The Government Man will be here early." He leaves and his wife pretties herself, putting on her best negligee. But instead of the Government Man, a "door-to-door" salesman specializing in photographing babies knocks at the door . . .

"Oh, Good morning, you probably don't know who I am, but I represent . . ."



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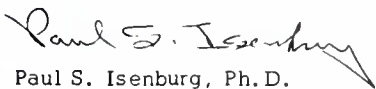
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"Oh yes, you needn't explain, my husband said to expect you."

"I make a speciality in babies, especially twins."

"That is what my husband said. Please sit down."

"Then your husband probably told you that . . ."

"Oh yes, we both agree that it is the best thing to do."

"Well, in that case we may as well get started."

Wife blushes . . . "Just where do we start?"

"Just leave everything to me madam, I recommend two in the bath, one on the couch and another two on the floor."

"Bath . . . tub . . . floor, no wonder Harry and I . . ."

"Well, my lady, even the best of us can't guarantee a good one every time, but say one out of six is sure to be a honey."

"Pardon me, but it seems a bit informal."

"No, indeed! In my line of business, a man can't do his best work in a hurry."

He opens his album and shows her his baby pictures.

"Look at this baby, it's a good job . . . Took four hours, but isn't she a beauty?"

"Yes, she's a lovely child."

"For a tough assignment, look at this child. Believe it or not, it was done on top of the bus on the way to Dover."

"My God!"

"It's not hard when a man knows his job. My work is a pleasure. I spent long years perfecting my technique. Now take this baby, I did it with one shot in Alexander's Window."

"I can't believe it . . ."

"And here is a picture of the prettiest twins in town. Turned out exceptionally well considering their mother was so difficult. I knocked off the job in Hyde Park on a Sunday afternoon. People crowded around four or five deep, pushing to get a look."

"Four or five deep . . . pushing to get a look?"

"Yes, it took more than three hours, but I had two Bobbies helping me. I could have done another shot before dark, but by this time the squirrels were nibbling at my equipment and I had to give it up. Well madam, if you are ready, I'll get my tripod and get to work."

"Tripod?"

"Oh yes. I always use a tripod to rest my equipment on. It is much too big and heavy for me to hold up for any length of time . . . Mrs. Smith, Good Lord! Mrs. Smith . . . You seem to have fainted . . ."

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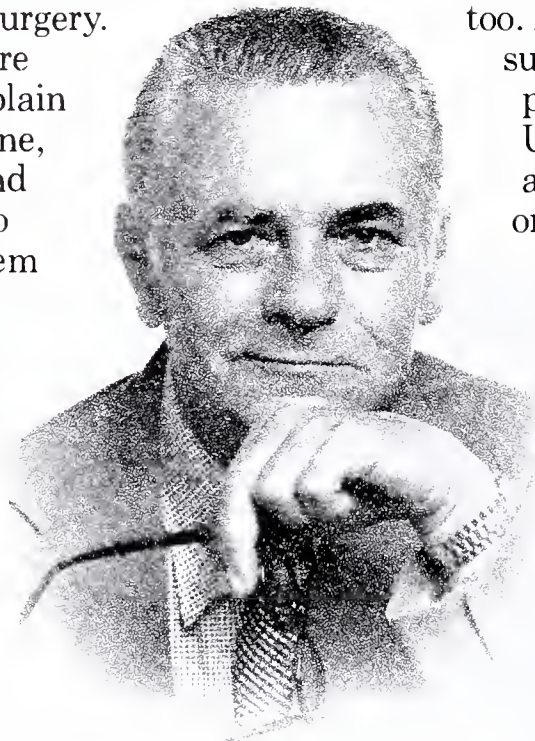
about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know.

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# Old Fashioned Dialogue is Back.

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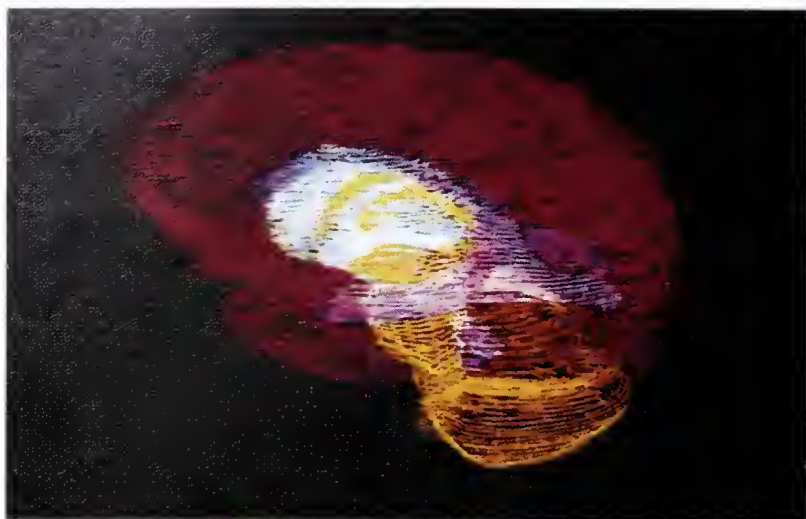
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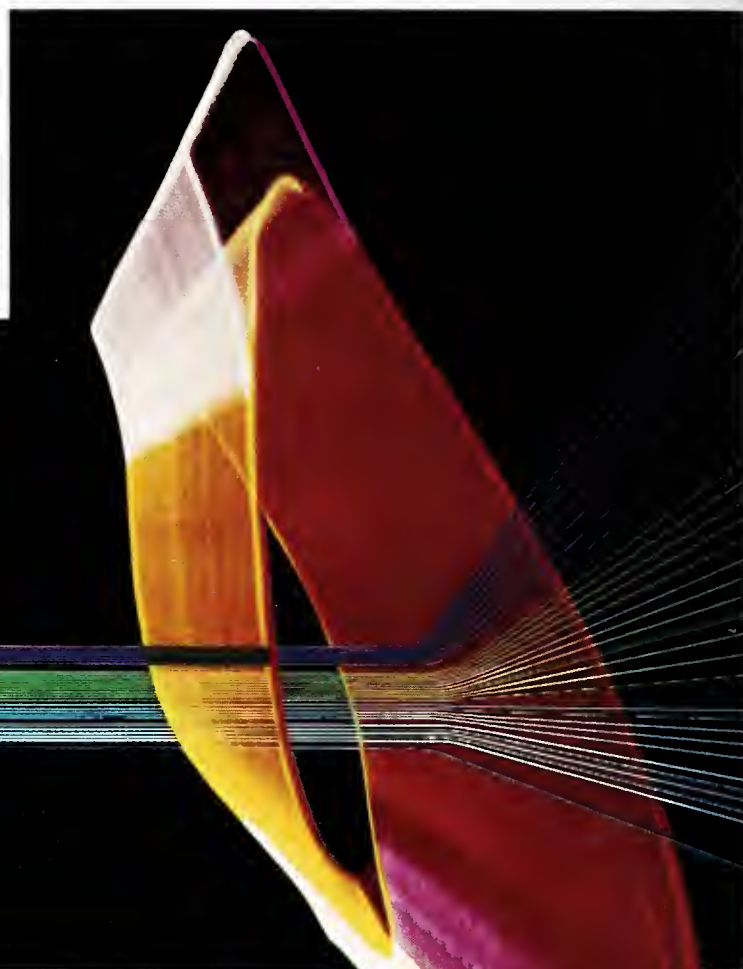
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**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants

may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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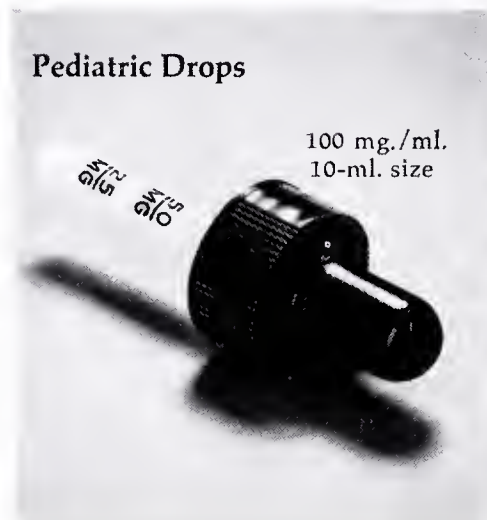
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*The reasons some people get depressed are different from the reasons other people get depressed—on an ethnic basis.*

## Psychocultural Study of Depression: A Pilot Study

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• *Hawaii's population is composed of a unique combination of polynesian, oriental, caucasian and cosmopolitan peoples and cultures. This influences Hawaii's mental health problems in ways not yet well understood. These several ethnocultural groups share a common language, English, and utilize the same mental health facilities. Hawaii's multi-cultural society thus offers a 'natural laboratory' for cross-cultural studies in which psychological stresses and their relationship to the pathogenesis of depression in a number of cultural groups can be simultaneously observed. Such studies, although very necessary, are rarely encountered in the literature, which is summarized below. These considerations have induced the Department of Psychiatry of the John A. Burns School of Medicine and the Queen's Mental Health Clinic to carry out psychocultural research in depression. The present report presents the results of a pilot study for this project.*

Depression affects people of all cultures in all parts of the world. The World Health Organization has therefore been actively concerned with this problem.<sup>1</sup> Singer<sup>2</sup> has extensively reviewed the literature on depressive disorders from a transcultural standpoint and has evaluated the methodological problems of cross-cultural research. Although depression is a clearly recognized and well-described psychiatric condition, there is substantial confusion concerning the various usages of the term,<sup>3</sup> and depressive nosology.<sup>4</sup> Moreover, absence of standardized and agreed upon diagnostic procedures and methods of investigation have limited the cross-cultural comparison of prevalence rates.<sup>5</sup>

In the past, most investigators have tended to study cultural variations of depressive clinical

pictures. For example, Murphy et al.<sup>6</sup> studied the symptomatology of depression in different parts of the world and reported that there is a basic depressive symptom-constellation, present in all cultures studied. Other associated symptoms—e.g., thought retardation, self-depreciation—may vary cross-culturally. Zung<sup>7</sup> used a Self-Rating Depression Scale to illustrate the existence of quantitative cross-cultural differences in baseline depressive symptomatology in the normal adult population. Tanaka-Matsumi and Marsella,<sup>8</sup> through word association studies, demonstrated differences between Americans and Japanese in the meaning and subjective experience of depression.

Although it has repeatedly been posited that depression is rare in less developed areas, Prince<sup>9</sup> has discussed the changing picture of the depressive syndrome in Africa; Binitie<sup>10</sup> has compared symptomatology of depression among Africans and Europeans, and Opler and Small<sup>11</sup> have elaborated cultural variables affecting somatic complaints and depression.

In spite of cross-cultural studies of the phenomenology of depression,<sup>12,13</sup> there are relatively few investigations relating the cultural aspects of psychological stress to depression.<sup>14</sup> A number of different psychological, pathogenetic formulations of depression have been offered. Among them are: (1) the idea that depression is related to orality and hostility;<sup>15</sup> (2) depression occurs as a reaction to loss of a loved object;<sup>16</sup> (3) depression is preceded by intense narcissistic needs<sup>17</sup> or a 'Depressive position';<sup>18</sup> or (4) is related to a loss of self-esteem.<sup>19</sup>

Cross-cultural investigation have sought to test these hypotheses. Fernando<sup>20</sup> compared social factors among Jewish and Protestant depressives in London, and reported that depression among Jews may be related to mental stress arising

This pilot study has been carried out at the Queen's Medical Center, Mental Health Clinic. The Center's permission and financial support from the Stanley N. Barbee Memorial Fund of the Queen's Medical Center to carry out this pilot study are greatly appreciated. We also wish to acknowledge the assistance of Joy Ashton.

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TABLE 1.—*Profile of Depression in Three Ethnic Groups.*

ETHNICITY SEX  ITEM	CAUCASIAN		JAPANESE		PT.HAWAIIAN	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
	(N=20) %	(N=20) %	(N=20) %	(N=20) %	(N=11) %	(N=20) %
AGE						
18-25	20	40	50	65	42	35
26-35	35	25	25	15	42	30
36-45	10	5	15	15	0	35
46+	35	30	10	5	16	0
MARITAL STATUS						
Married/Cohabiting	40	20	25	25	42	40
Single	20	45	55	55	16	10
Divorced/Separated/Widowed	40	35	20	20	42	50
EDUCATION						
High School	45	45	35	45	92	75
College	55	45	55	55	0	25
No information	0	10	10	0	8	0
FINANCIAL STATUS						
(Supported by:)						
Self	55	35	70	45	42	30
Parent	0	15	25	20	8	0
Spouse	5	5	0	20	0	15
Public Finance	40	45	5	10	50	55
PAST ADJUSTMENT						
(Areas of Problems)						
Social Group Participation (in youth)	25	15	60	10	25	20
Family Relations	75	65	55	80	58	70
Marital Relations	75	85	35	60	92	90
Psychosexual	15	30	15	35	58	35
Social Relations (as adult)	55	50	40	40	58	35
Occupation	55	40	40	20	75	55
Financial	40	45	25	5	42	50
Health	30	40	30	20	50	40
LIFE EVENTS						
Prior to onset of Depression						
Death	5	10	15	5	8	5
Divorce/Marital separation	25	10	25	5	16	0
Broken Romance	10	30	10	15	16	35
Pregnancy or Abortion	10	10	0	0	0	0
Birth of Child	0	0	10	10	8	0
Sexual Difficulties	15	5	5	5	8	10
Interpersonal Problems	35	45	20	65	75	80
Difficulties at Work	20	15	15	10	8	20
Job Change	25	10	10	5	33	10
Change of Life Circumstances	40	60	35	30	0	40
Financial problems	45	40	15	5	33	50
Physical Illness	35	20	10	5	42	45
Family Member Problems	10	0	0	5	0	20
CLINICAL SYMPTOMS						
Depressive Mood	100	100	90	95	92	100
Loss of Interest	30	40	5	10	33	15
Sleep Disturbance	55	45	25	40	33	40
Anorexia	20	20	5	15	25	25
Weight Change	20	25	5	10	16	25
Psychomotor Retardation	15	20	15	10	8	5
Agitation	35	15	20	15	25	15
Fatigue	20	25	0	10	8	5
Loss of Libido	15	5	0	10	0	0
Inability to Concentrate	10	25	10	25	8	30
Indecisive, Slowed Thinking, Poor Memory	0	0	15	10	0	10
Withdrawal	65	65	30	35	33	45
Sense of Worthlessness	15	30	20	30	8	5
Sense of Helplessness	15	35	5	15	25	40
Suicidal Idea	50	40	35	35	42	55
Hypochondriacal	5	5	0	10	0	15



TABLE 1.—*Profile of Depression in Three Ethnic Groups.*

(Con't.)

ETHNICITY SEX	CAUCASIAN		JAPANESE		PT HAWAIIAN	
	MALE (N=20)	FEMALE (N=20)	MALE (N=20)	FEMALE (N=20)	MALE (N=11)	FEMALE (N=20)
ITEM	%	%	%	%	%	%
Apprehension	35	25	30	20	16	50
Obsessive Phobia	10	5	5	0	0	15
Suspicious	5	10	0	5	16	0
Aggressive	0	5	5	5	42	5
PSYCHOLOGICAL CONDITION ASSOCIATED WITH DEPRESSION						
Shame/Guilt	25	30	10	45	25	30
Fear	25	20	5	10	0	35
Hopelessness	25	10	10	5	8	40
Anger	30	30	15	35	42	40
Hostility	5	5	15	5	16	10
Insecurity	5	30	35	40	0	50
Loneliness	20	30	30	15	8	50
Feeling of Failure	30	15	35	30	50	15
Lack of Achievement	20	5	40	20	16	10
Loss of Incentive	10	5	10	0	8	5
Conflict in Decision Making	0	15	0	15	0	15
Loss	25	20	20	5	8	45
Anxiety	35	10	15	15	8	25

ing from 'marginality,' with single Jewish men most vulnerable to depression.

Krauss<sup>21</sup> examined the population of Ashanti in Central Ghana, and explained that multiple factors in this culture act in concert to produce women of a certain psychological orientation which renders them particularly susceptible to depression.

In all this body of work, there are very few cross-cultural studies which involve more than 2 cultural groups systematically investigated by the same research group, comparing psychological stresses and their relationship to the dynamics of depression.

### Method

The medical records of Queen's Mental Health Clinic patients who had been diagnosed as having depressive neurosis or reactive depression were utilized for this pilot study. Psychotic depressions, and depressions in patients with other concurrent psychotic diagnoses were excluded. These diagnoses carry implications of possible genetic or biochemical factors which might obscure the differences produced by cultural influence.

A total of 11 part-Hawaiian men, 20 caucasian and 20 Japanese men, and 20 women of each of the 3 ethnic groups were selected for study.

These ethnic groups were chosen because they are the 3 largest groups in the Clinic population, and because they are thought to have contrasting cultural systems. Ethnicity is based either on the patient's or the mental health worker's statements. 'Part-Hawaiian' is generally defined here as more than 1/16 Hawaiian heritage, by parentage.

Demographic data and information on education, financial status and previous adjustment problems, the history of the present depression, life events prior to depression, and clinical symptoms and psychological condition associated with the depression were collected, as fully as clinic records allowed, in order to "locate" and characterize stresses significantly related to the development of depression.

### Preliminary results

All the information obtained is presented by percentages, for men and women of the 3 ethnic groups. (Table 1.) Such data were statistically analyzed by ranking the responses for each ethnic group and sex in ascending order of percentage of individuals appearing in the response. The extent and significance of the correlation between rankings was then determined by computing Spearman's rank-order correlation coefficient. (Table 2.) A significant rank-order correlation coefficient is evidence of significant similarity between the rank ordering of the responses in the 2 groups being compared.

According to this analysis, there is no evidence of significant correlation in past adjustment problems, except for caucasians of both sexes thus, the 3 ethnic groups vary basically in this regard. With respect to life events prior to depression, the coefficients vary between comparisons, without any particular pattern. As for the clinical symptoms, there are significant similarities in every comparison, indicating that there is no evidence of ethnic difference or sex difference in clinical symptoms. In regard to psychological condition associated with depression, generally there is no similarity except when

TABLE 2.—Rank Order Correlation Coefficients.

COMPARISON	SCORED VARIABLE			
	PAST ADJUSTMENTS	PRIOR EVENTS	CLINICAL SYMPTOMS	PSYCHOLOGICAL CONDITION
Caucasian male x Caucasian female	.905*	.740**	.808**	.214
Japanese male x Japanese female	.196	.589*	.795**	.364
Part-Hawaiian male x Part-Hawaiian female	.673	.496	.558*	-.235
Caucasian male x Japanese male	.375	.559*	.646**	.129
Caucasian male x Part-Hawaiian male	.643	.497	.630**	.497
Japanese male x Part-Hawaiian male	-.042	.321	.520*	.396
Caucasian female x Japanese female	.667	.565*	.785**	.622*
Caucasian female x Part-Hawaiian female	.774	.765**	.680**	.809**
Japanese female x Part-Hawaiian female	.476	.530	.740**	.275

\*P&lt;0.05

\*\*P&lt;0.01

we compare caucasian and Japanese women and caucasian and part-Hawaiian women.

By focusing on the content of the information obtained, the profile of depression among three ethnic groups can be described as follows:

#### A. CAUCASIAN MEN

The caucasian men represented a wide age range; about 1/3 were over the age of 45. More than 1/3 were divorced, and about 60% had been in Hawaii less than 5 years. More than half had been educated beyond high school, and had demonstrated good academic performance. About 55% were currently employed and self-supporting, while 40% were on some form of public support.

Past histories indicated that the men had multiple life adjustment problems, mainly in the areas of family (75%), marriage (75%), social relations (55%), and occupation (55%) resulting in lifestyles that tended to be chaotic. Depression was precipitated largely by financial problems (45%), change of life circumstances (40%), interpersonal conflicts (35%), or physical illness (35%).

The clinical picture of depression was characterized by the presence of striking symptomatology: manifestations of withdrawal (65%); suicidal ideas (50%); sleep disturbances (55%); anxiety (35%); and agitation (35%). Depressive mood was present in 100%.

Psychological pathogenetic formulations emphasized chaotic lifestyle as a major antecedent for depressive episodes: repeated marital failures, disappointments and changes in non-marital heterosexual matings, frequent job

changes, changes in residence, and a tendency to poor coping techniques, ill-considered or impulsive. Depression tended to occur after middle age.

#### B. CAUCASIAN WOMEN

Most of the caucasian women studied fell into one of two age groups: under 30 or over 50. About 45% were single, 35% divorced. Half had come to Hawaii somewhat recently. They were fairly well educated; 45% had beyond high school education. Yet, nearly half were financially dependent on welfare or other sources than self or family support.

Past histories indicated that all the women had multiple life adjustment problems: marital relations (85%), family (65%), social relations (50%), financial problems (45%). Lifestyles again tended to be chaotic.

Life events that had occurred before the development of depression were: major change in life circumstances—e.g., retirement, moving (60%); interpersonal conflict (45%); financial problems (40%), and broken romance (30%). In addition to depressive mood and sleep disturbances, prominent symptoms included loss of interest (40%), withdrawal (60%), sense of helplessness (35%) and suicidal ideas (40%). The women's depressions were thought to be largely the result of marital failure, financial instability, and vulnerability to change in life circumstances at the involutional age.

#### C. JAPANESE MEN

Most of the Japanese men in this project were young, half between the ages of 18 and 25. About 55% were single and 25% were financially de-



pendent on their parents. Most were well educated, 55% having gone beyond high school. The majority (70%) were self-supporting, only 5% on welfare.

Most of them (60%) had trouble participating in social group activities. They had experienced difficulties with family (55%), in social relationships (40%), and in occupation (40%). In other aspects of previous adjustment, they had encountered relatively fewer prominent problems than other groups. About 20% had maintained smooth and 35% marginally smooth life patterns.

'Life events' prior to the occurrence of depression were unremarkable, except for change of life circumstances (35%). Clinical symptomatology tended to be less dramatic. Psychologically, the patients were troubled by their lack of achievement (40%) or were preoccupied with a sense of failure (35%), and insecurity (35%). Thus characteristically they appeared to become depressed more often because of internal conflict (25%) rather than because of external causes.

#### D. JAPANESE WOMEN

Of the Japanese women, 65% were between the ages of 18 and 25, and most of them were still single (55%). Half were educated above high school level. Half were financially self-supporting, and 40% were dependent on parents or spouse. Only 10% were on welfare.

In the past, most of their adjustment difficulties had centered around family (80%) or marital relationships (60%). These problems may have led them to choose chaotic lifestyles, such as running away from home, hasty marriages or marriages to defy parents, resulting in the breaking of traditional ties and deprivation of family support system. Depression was associated with a sense of guilt or shame for 45%, with feelings of insecurity (40%) or anger (35%). Others felt socially inadequate, had difficulty dating or suffered doubts regarding their femininity.

#### E. PART-HAWAIIAN MEN

Most of the part-Hawaiian men were between 18 and 35. None had gone beyond high school. About  $\frac{2}{3}$  were currently unemployed and half were on public assistance. In the past, the majority of them had had multiple problems in marriage (92%), work (75%), family relations (57%), psychosexual adjustment (58%), social relations (58%), health (50%) and money matters (42%).

Interpersonal conflicts as well as reality problems, e.g., health, job change, financial problems, resulted in depression associated with anger and a sense of failure for this group. When the depression occurred, aggressive behavior rather than withdrawal or self-destructive behavior was manifested more frequently (42%) than in other groups.

#### F. PART-HAWAIIAN WOMEN

These women were between ages 18 and 45.

Only 25% had gone beyond high school. About 80% of the group had been relatively unsuccessful in school, receiving C or D grades. Some were school drop-outs. Only 35% were working. More than half were on welfare. Most had been married, but half were divorced.

As regards previous adjustment, 90% had had marital difficulties, 70% troubled family relations, and more than half occupational/financial problems. Their lifestyles were almost exclusively chaotic. Significant interpersonal conflicts prior to onset of depression showed up in 80% of the group. About 35% had had broken romances; 50% "reality" problems, e.g., financial; and 45%, physical illness. Depression appeared related to repeated stress or chaotic lifestyles. Associated with the depressions were intense mixed feelings of hopelessness (40%), insecurity (50%), loneliness (50%), feelings of loss (45%), anger (40%), and fear (35%).

### Discussion

Using these preliminary findings, one may speculate about the ways in which cultures shape profiles of depression in different ethnic groups, and how culture contributes to the development or prevention of depression.

It may be hypothesized that a culture shapes circumstances which make people vulnerable to depression. Consider, as an example, a society such as that of the caucasian group. Such a subculture strongly emphasizes individual freedom and independence. This society provides educational opportunities, and allows social mobility and frequent changes of occupation and residence. In this setting, many people attempt to cope with difficulties by breaking marital bonds, changing jobs or moving to a new place. Consequently they lose family and group supports. When, in middle age and after, the ability to cope by making changes diminishes, they become vulnerable to depression.

A contrasting example comes from the Japanese group. In such a subculture, family-social obligations are usually placed above individual needs, while great value is placed on achievement. A Japanese suffers intrapsychically when he feels he has not met these standards. This has been particularly true of Japanese men. Such a person is apt to feel inadequate and a failure; he has only limited external ways to cope with personal difficulties. When Japanese try to cope by breaking traditional ties (as some women have), they may be completely rejected by the group and deprived of any available support system. They then become especially vulnerable to depression.

A third example is suggested by the situation of the part-Hawaiian group. Members of this group tend to be educationally deprived and cannot compete as successfully as others in the

occupational sphere. Thus, they face a variety of material-financial problems, and may have a pervasive sense of inadequacy, of being 'second-best.' These factors may create susceptibility to depression.

These formulations are necessarily highly tentative, for a number of reasons. First of all, the data was recorded originally by different clinicians whose 'inter-rater reliability' is unknown. The caucasian sample, particularly, may not be representative of caucasians in general. A large proportion of this sample did not originate in Hawaii. It is at least plausible that many may have come to Hawaii as a result of unsatisfactory or unsuccessful adjustment elsewhere, and the sample may thus be rather heavily weighted toward psychopathology.

Another factor is the contamination by socioeconomic class, for which controls could not be established. Part-Hawaiians, for example, tend to be lower in socio-economic status than either the caucasians or the Japanese.

Finally, there is the relative imprecision of the diagnosis of 'neurotic' or 'reactive' depression. This category, as currently defined in the official classification of psychiatric disorders (DSM-II) can include both brief episodes which include depressive symptomatology under conditions of stress and chronic 'characterologic' depressions. These conditions may well be quite different in epidemiology. The differences in age of onset and symptom-picture among the ethnic groups

under study could represent differential prevalences of these conditions in our samples. (However, differential prevalences might possibly be consequences of culture.)

Although formulation is, at this stage of investigation, speculative, it is nevertheless useful, provided the speculations can be framed as testable hypothesis. It should be possible, for example, to test the hypothesis that depression in Japanese men is accompanied to a significantly greater degree by guilt and shame over failure to measure up to internalized norms of behavior and achievement, than is the same disorder among caucasian men.

Similar hypotheses can be erected for other possible ethnocultural differences suggested by this pilot study. In general, a prospective as opposed to retrospective methodology, with uniform data collection, definitions and criteria, and controls over reliability, will be required at the next level of investigation. Such studies are presently being planned.

Hawaii provides a challenging variety of ethnic-cultural examples for study. Well-designed, intensive case investigations and the systematic and prospective examination of clinical material could allow us to develop a psychocultural profile of depression for each of the various ethnic groups. Based on such findings, better hypotheses of the ways in which culture relates to the problem of depression can be tested and developed.

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*Provoking factors may include viruses, HLA.*

# Childhood Diabetes Mellitus in Hawaii

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● *The genetic etiology of diabetes mellitus seems unquestioned. However, the mode of inheritance of diabetes mellitus has not as yet been clarified. Recent work appears to imply that diabetes mellitus is a genetically heterogeneous group of disorders.<sup>1,2,3</sup> Genes, viruses, and immunity all play a role in this condition.*

Twin studies<sup>4,5</sup> have shown that maturity-onset diabetes mellitus (MODM) is probably one genetic disease, whereas in juvenile-onset diabetes mellitus (JODM), genetic factors might not be the only factors involved.

Histocompatibility studies<sup>6</sup> in diabetes have shown an increased frequency of HLA-B 8, HLA-BW 15, HLA-DW 3, and HLA-DW 4 in JODM. HLA-B 7 has been reported to be protective.<sup>7</sup> HLA studies in twins<sup>8</sup> have indicated that the genetic pathway involved in MODM is not HLA mediated, whereas in JODM different HLA mediated genetic pathways may be involved.

## Viruses and Diabetes

Viruses have been implicated in JODM through epidemiological studies and as a complication of proven viral infections. Mumps,<sup>9</sup> rubella,<sup>10</sup> and coxsackie B<sub>4</sub><sup>11</sup> have all been implicated.

Autoimmune diseases such as thyroiditis, Addison's disease, myasthenia gravis, and pernicious anemia have all been associated with diabetes mellitus. There appears to be a high genetic predisposition in patients with autoimmune disease and, not infrequently, viruses have been implicated in the onset of these disorders.

Studies<sup>12,13</sup> of antibodies to pancreatic islet tissue in patients recently diagnosed as having JODM have yielded positive results in 20 to 60% of patients, depending on how long they have had their condition. The antibodies disappear with time.

Hawaii is a small state with a stable multi-racial population. The social, cultural, and dietary habits of the many ethnic groups in Hawaii are influenced by both Asian and Western cultures. Hawaii's geographic location and attraction as a tourist destination for both the East and the West subjects the island population to viral and other epidemiological infections originating from both the East and the West. Epidemiologic studies in this small state might add helpful information to our knowledge of childhood diabetes mellitus.

## Materials and methods

All cases of children developing diabetes mellitus in Hawaii and available to the author were reviewed. This included all patients admitted to Kauaikeolani Children's Hospital over a period of approximately 8 years and all patients seen in the author's private practice.

JODM cases were quite classical and easily defined. MODM cases were defined as children, with abnormal glucose tolerance tests (GTT), who had been classified as having diabetes mellitus. These patients were frequently obese, did not necessarily have the classical signs and symptoms of diabetes mellitus, had no ketoacidosis, and did not require insulin therapy. Unfortunately, very few had insulin studies done during their GTT.

## Results

A total of 95 cases of children with documented diabetes mellitus were found with

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enough information to be helpful in this study. (Table 1) There were 2 cases of neonatal diabetes mellitus. The remaining 93 cases could be differentiated into either MODM or JODM by their clinical picture. About 19% (18 cases) were classical MODM and 81% (75 cases) classical JODM.

TABLE 1.—*Differentiation of Hawaiian Cases Studied*

Neonatal	2
JODM	75
(Juvenile—Onset Diabetes Mellitus)	
MODM	18
(Maturity—Onset Diabetes Mellitus)	
TOTAL	95

In Table 2, all of the MODM cases are presented. Almost by definition, all patients were obese. Although the majority of patients were adolescents, the 2 youngest patients were diagnosed at 2 and 5 years of age and were of Japanese ancestry. Only 9 cases of MODM had been hospitalized and, in only 4 cases, the primary diagnosis was diabetes mellitus.

A total of 11 patients had conditions that led to the ultimate diagnosis of MODM. A central nervous system disorder was found in 6 patients, either mental retardation or a neuromuscular condition. The diabetes mellitus had been found in the workup of their central nervous system condition. Prader-Willi Syndrome with MODM was found in 2 cases.

Hypertension and obesity was seen in 2 cases. The hypertension was initially thought due to obesity. The patients were found to have MODM during the workup of their hypertension.

One patient had juvenile rheumatoid arthritis and was severely incapacitated. She was extremely obese due to inactivity. Her MODM was found prior to starting therapy for her J.R.A.

Two patients had gonadal dysgenesis. In both cases, the referral was made because of glycosuria and not because of the typical signs and symptoms of Turner's syndrome exhibited by both cases. One patient had an XO chromosomal karyotype, whereas the other had a Mosaic XO/Ring X chromosomal karyotype.

All the cases of JODM had classical symptoms of diabetes mellitus and had been hospitalized with a primary diagnosis of diabetes mellitus.

Table 3 shows the racial, sexual, and family history backgrounds of the 75 cases of JODM. The sex ratio of these cases shows a higher female preponderance. Of these cases, 55% had a positive family history of diabetes. This high positive family history was particularly noticeable in the caucasian and cosmopolitan groups. The sex ratio and family history findings are similar to those found in the MODM cases. The family history in the Japanese cases (MODM, JODM, or total number) was positive in only 20 to 25 percent of cases. This is similar to the familial incidence of 20 to 30 percent in children with diabetes mellitus found in Japan.<sup>14</sup>

Table 4 indicates the racial background of the cases of JODM as compared to the racial background of the population in Hawaii. The percentage of Japanese, caucasian, and Chinese cases are the same as the proportion of these races found in the community. The cosmopolitan or mixed racial group had a much higher incidence of JODM than would be expected from the population in the community. Only one case was found in a child with Filipino ancestry.

An attempt was made to break down the cosmopolitan group to see if any factors could be found making this group more susceptible to JODM. The racial mixture in the cosmopolitan group reflects a social-cultural aspect of the island people. Filipino ancestry does not appear to be protective in these mixed racial cases. At least 6 cosmopolitan patients had Filipino ancestry.

We were unable to equate the etiology of any cases to viral epidemics in the community. Many children did have viral illnesses that precipitated admission to the hospital. This was found as often in 2nd and 3rd admissions as in initial admissions. No case was found to have had congenital rubella, although Hawaii did have a large epidemic in 1964-65.

Proven thyroiditis developed in 3 cases. This incidence may be higher, since only one of the cases had the thyroiditis at her initial hospitalization for diabetes. The other 2 cases developed thyroiditis later in the disease. No ongoing information is available in a high proportion of these cases.

TABLE 2.—*Clinical Features of MODM Cases*

RACE	NUMBER	SEX F/M	FAMILY HISTORY	MISCELLANEOUS
Japanese	8	4/4	2	2—M.R. 2—Hypertension 1—Prader-Willis
Cosmopolitan	6	5/1	4	1—M.R. 1—J.R.A.
Caucasian	1	XO/Ring X	1	1—Gonadal dysgenesis
Filipino	2	1/1	1	1—M.R. 1—Prader-Willis
Chinese	1	XO	1	1—Gonadal dysgenesis
TOTAL	18	10/6	9	11—All obese



TABLE 3—Clinical Features of JODM Cases

RACE	NUMBER	SEX F/M	FAMILY HISTORY	MISCELLANEOUS
Japanese	14	9/5	3	
Caucasian	20	12/8	10	1—Thyroiditis
Cosmopolitan	37	18/18	25	1—Thyroiditis
Filipino	1	1/0	0	
Chinese	3	2/1	3	1—Thyroiditis
TOTAL	75	42/32	41	

### Comment

#### 1. MODM.

MODM has been reported as being rare in children. Most pediatric textbooks state that all children with diabetes automatically have JODM. Some textbooks briefly mention MODM as occurring with a very low incidence. Drash<sup>15</sup> estimates that MODM occurs in about 5% of children with diabetes mellitus. The 18 cases (18%) found in this study is a much higher incidence than expected. It is not as high an incidence as reported in Japan where 30% of their diabetic children have MODM.<sup>16</sup> Many of the Japanese cases were discovered by finding glycosuria on routine urinalysis of primary and junior high school students in metropolitan Tokyo from 1974 to 1978. They were proven to have diabetes mellitus by positive GTT's.

In the Hawaii study, the Japanese cases have a MODM/JODM ratio of  $\frac{8}{14}$  for an incidence of 36%; the caucasian cases have a MODM/JODM ratio of  $\frac{1}{20}$  or 4.8%; and the cosmopolitan cases have a MODM/JODM ratio of  $\frac{6}{37}$  or 14%. These figures would seem to imply a racial reason for the higher incidence of Japanese (40%) and cosmopolitan (35%) patients with MODM than would be expected by the racial percentage of these groups in the Hawaiian population.

Whether the varying incidence rate of MODM is an ascertainment problem or a racial difference is difficult to tell. Routine, yearly urinalysis in children is not recommended by the Committee on School Health of the American Academy of Pediatrics. Obese children are not routinely worked up for diabetes mellitus. In a prospective study of 353 obese children and adolescents in Japan, 16% were found to have MODM.<sup>17</sup>

The incidence of MODM in childhood may

be higher than expected. Some factors seem important. The racial background of the patient, a positive family history of diabetes, obesity, non-renal hypertension, and gonadal dysgenesis may all be definite risk factors increasing the possibility of developing MODM in childhood.

The natural history of children with MODM needs further definition and these patients should be followed throughout life. The 2 youngest patients had a marked improvement in their appearance, stopped having glycosuria, and had a complete reversal of their abnormal GTT on dietary therapy. Two other patients have successfully lost weight on dieting and no longer have glycosuria. Their GTT's are as yet abnormal. One case was originally thought to have MODM but eventually developed JODM. His obesity and glycosuria responded to dietary therapy. His GTT did not return to normal and within 3 months of losing his excess weight and glycosuria, the child developed classical signs and symptoms of JODM requiring insulin therapy.

#### 2. JODM

JODM in Hawaii has been shown to have a racial implication in only 2 racial groups. A Filipino racial background appears to be protective in this condition. Children with a mixed racial background appear to be more susceptible to JODM. If this mixed racial background contains Filipino ancestry, the apparent protection of the Filipino ancestry is lost. All the other racial groups in Hawaii do not appear to be at a higher or lower risk of developing JODM.

Studies of immune diseases in children in Hawaii have not been done. Thyroiditis is rarely seen in Filipino children. Nephrosis, systemic lupus erythematosus, and juvenile rheumatoid arthritis are commonly seen in Filipino children in Hawaii.

TABLE 4—Comparison of Racial Background of JODM Cases to the Racial Background of the Community.

RACE	HAWAII STATE	OAHU* ISLAND	K.C.H.** ADMISSIONS	JODM
Japanese	26.6%	14.2%	15%	19%
Caucasian	27.7%	28.2%	20%	27%
Cosmopolitan	28.8%	25%	27%	47%
Filipino	10.2%	17.1%	18%	1.4%
Chinese	4.3%	4.1%	3%	4.1%

\*The majority of cases came from this island.

\*\*The majority of cases were hospitalized at Kapiolani Children's Hospital (K.C.H.).

HLA antigens have been measured in Hawaii and found to be similar to the HLA antigens found in the same races in their native countries. Our diabetic population has not as yet been tested for HLA antigens. Although the Filipino children may have other, as yet unidentified protective HLA antigens, HLA-B 7 is rarely found in Filipinos. We do not know as yet if there is a higher incidence of HLA-B, HLA-BW 15, HLA-DW 3, or HLA-DW 4 in our cosmopolitan patients. HLA studies in Japan has not shown a higher incidence of these HLA antigens in their diabetic population. These HLA antigens are rare in the Japanese population as a whole. HLA-BW 54 is found in a high frequency in Japanese diabetics.<sup>18</sup>

### Summary and Abstract

A large number of cases of childhood diabe-

tes mellitus occurring in Hawaii has been reviewed for epidemiologic data. Many of the findings that differed from previous American studies may be related to racial factors. MODM cases as a whole were found in a higher incidence than would be expected. This was particularly true in children of Japanese ancestry where the incidence of MODM was as high as found in Japan. The percentage of children of Japanese ancestry with JODM was found in the same proportion as Japanese people in the Hawaiian community. This was true of all racial groups except for the children of Filipino ancestry and the children of mixed racial ancestry (cosmopolitans). JODM was rarely found in children of Filipino ancestry although Filipino ancestry was not protective in cosmopolitan children. Cosmopolitan children had an extremely high incidence of both MODM and JODM.

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Proceedings of  
The House of Delegates



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George Goto  
Elmer Johnson  
R. Bruce Joseph  
Gail Li  
Gabriel Ma  
L. Q. Pang  
Alexander Roth  
Calvin Sia  
Robert Simmons  
Neal Winn  
Sakae Uehara (Maui)

#### **Sports Medicine**

B. R. Mehta, Chairman  
Roy Kuboyama, Commissioner  
James Bennett  
Gladys C. Fryer  
Robert Harvey  
Virgil Jobe  
Rowlin Lichter  
Walter Loo  
Wallace Loui  
Gerald Mayfield  
George Mills  
Ichiro Nadamoto  
Robert Nemechek  
Thomas Richert  
Betty Soo  
Patrick Walsh  
Patrick Cockett (Kauai)  
Y. Miyashiro (Kauai)  
Russell Stodd (Maui)  
Richard West (Maui)

#### **Substance Abuse/Pharmacy**

James Lumeng, Chairman  
Roy Kuboyama, Commissioner  
Edwin Curphey



Gladys Fryer  
Russell Hicks  
Virgil Jobe  
Lawrence Lan  
J. K. Sims  
Jose Romero (Maui)

#### TV-Radio

John Corboy, Chairman  
Philip McNamee, Commissioner  
Paul Berry  
Gunther Hintz  
Rowlin Lichter

Sigdian Lim  
David McEwan  
Meredith Pang  
Niranjan Rajdev  
Robert Schulz  
Ronald Yamaoka  
Mark Wentworth (Kauai)

#### Tel-Med

Philip McNamee, Commissioner  
Gerald Hiatt  
Rowlin Lichter

#### Worker's Compensation

Bernard Scherman, Chairman  
William Dang, Commissioner  
Francis Au  
Clifford Chock  
Albert Chum-Hoon  
Robert Clingan  
Raymond Dusendschon  
Casimer Jasinski  
David Kimura  
Rowlin Lichter  
Herbert Luke  
Gary McQueen  
Maurice Nicholson  
Dan Yoshioka

## PROCEEDINGS OF THE HOUSE OF DELEGATES

### 123rd Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates meeting was called to order by President George Goto on Monday, October 8, 1979, at 1:30 p.m. in the Bora Bora Room of the Ilikai Hotel. Dr. Neal E. Winn, Secretary, called the roll. Present were: Drs. George Goto, Douglas B. Bell II, Neal Winn, William Hindle, Walter W. Y. Chang, Ben Azman, Yonemichi Miyashiro, Nadine Bruce, Michael McCabe, Denis Fu, Arch Wigle, Herbert Chinn, William Iaconetti, George Mills, William Dang, Calvin Sia. Delegates from county societies included: Honolulu—Murray Berger, Ann Catts, Benjamin Chang, Richard Fardal, Henry Fong, James Lumeng, Victor Mori, Ronald Peroff, J. I. Frederick Reppun, Myron Shirasu, E. Lee Simmons, Patrick Walsh, Carl Boyer, Claude Caver, Gordon Ing, Charles Judd, Thomas Kobara, Donald Sroat, Richard Tesoro, Herbert Uemura, Thomas Whelan, Donald Char, Grover Batten, Henry Yokoyama, George Suzuki; Maui—Lawrence Allred, Sakae Uehara, Donna McCleary; Kauai—John Newman; Hawaii—James Phillips, Ruben Casile, Thomas Chen; Medical Student Representative—Eric Matayoshi.

Dr. William Dang was appointed to serve as parliamentarian for the meeting. Drs. Nadine Bruce and Thomas Whelan were appointed sergeants at arms.

The minutes of the 122nd Annual Meeting as published in the December 1978 issue of the HAWAII MEDICAL JOURNAL were approved.

The reports of the President, Secretary, Treasurer, and component societies were included in the delegates handbook and referred as indicated. The resolutions were assigned to reference committees.

The House of Delegates ADOPTED BY ACCLAMATION the following resolution:

#### MEMORIAL RESOLUTION

##### FELIX J. LAFFERTY, M.D.

Introduced by the HMA Public Affairs Committee

WHEREAS, on April 4, 1979, Felix J. Lafferty, M.D., of Honolulu, Hawaii, a member of the Honolulu County Medical Society and the Hawaii Medical Association since August 16, 1960, passed from our midst; and

WHEREAS, He is remembered for his years of service as an outstanding physician and an example of the finest traditions of medicine in his service to his patients and to his community; and

WHEREAS, He served his profession unselfishly at many levels of the county and State medical societies, including Treasurer and Secretary of the Honolulu County Medical Society and a Councilor for the Hawaii Medical Association; and

WHEREAS, In recognition of the valuable contributions he made to organized medicine and the community in Honolulu, he was accorded high honor by his colleagues, being elected President-elect of the Honolulu County Medical Society and to have served as its President next year; therefore be it

*Resolved*, That the House of Delegates of the Hawaii Medical Association express its profound sense of loss on the occasion of the death of Felix J. Lafferty, M.D.; and be it further

*Resolved*, That this resolution be adopted by acclamation by the members of the HMA House of Delegates and a copy of the resolution sent, with deepest sympathy, to his family.

\* \* \*

Reference committees were appointed as follows: Public Health and Education—Denis Fu (Chairman), Carl Boyer, Donald Sroat, Thomas Whelan; Miscellaneous—James Lumeng (Chairman), Ben Azman, Richard Fardal, Patrick Walsh; Finance and Administration—Ann Catts (Chairman), J. I. Frederick Reppun, Yonemichi Miyashiro.

\* \* \*

The reference committees were in session October 3 beginning at 2:00 p.m.

\* \* \*

The second session of the House of Delegates was called to order on Wednesday, October 10, 1979, at 1:30 p.m. Also present were: Drs. Robert Clingan, Leonard Howard, and O. D. Pinkerton. Delegates also present were: Honolulu—Fred Gilbert, Ralph Beddow, Virgil Jobe, Ramon Sy. Delegates Boyer, Char, Fong, Mori, Seto, Sroat, Suzuki, Tesoro, Uemura, and Yokoyama were absent the second day.

AMA President Hoyt D. Gardner was asked to address the House of Delegates. Dr. Gardner spoke on the past accomplishments and contributions of medicine to our country and how medicine as a group can affect the betterment and future of our society. He also touched on the subject of national health insurance.

\* \* \*

## Reference Committee On Public Health and Education

### Bureau of Research and Planning

**ACTION: Approved as amended.**

The Bureau of Research and Planning focused on two major areas during the year: a Diabetes project and exploration of Health Maintenance Organizations through the State Medical Association.

A Diabetes project was submitted to HEW to develop a

diabetes registry with follow-up education and training of diabetes. Considerable effort and time was placed in developing this project but, unfortunately, the funding was lacking from HEW.

Exploration of Health Maintenance Organization and specifically the development of Independent Practice Association (IPA) was pursued. Much time was spent on reviewing the various developments of IPA throughout the nation, especially the administration of such plans, the acceptance by the public and physicians, and management of the plan. Meeting was held with Albert Yuen, executive Director of Hawaii Medical Service Association, to seek out his thoughts on the development. (Currently, Kaiser is the only accepted HMO by HEW and the community health plans of HMSA are not officially recognized as an HMO of HEW). HMSA would prefer small medical groups coming out with their own IPA geographically and be competitive within each County.

The seeking out of other federal grant programs for the Hawaii Medical Association was continued throughout the year. Unfortunately, with the tight budget in Washington there are very few projects like the emergency medical services program and cancer in the immediate horizon.

#### *Recommendations:*

- (1) Continue to search for viable projects for the Medical Association;
- (2) Support County Societies development of IPA if requested.

CALVIN C. J. SIA, M.D.

## AMA Delegate

**ACTION: Approved with the recommendation that in the future, president-elects of the component medical societies be encouraged to attend the annual meeting of the AMA.**

There were no earth-shaking decisions made at the Annual Meeting of the House of Delegates this July. However, I would like to report several items which may be of interest. This is the first Annual Meeting in which the scientific program was not held in conjunction with the Annual Meeting of the House of Delegates. There were 262 resolutions and reports which were considered. New delegates were accepted from the American College of Nuclear Medicine, the Society of Thoracic Surgeons, and the American Intra-Ocular Implant Society so that as it now stands, 57 of the members of the House represent specialty societies out of a total of 277 delegates.

The Ad Hoc Committee on Medical Ethics submitted its report. After almost one whole morning of deliberations, the final decision was to distribute this report to each state medical association, county medical society, and national specialty society for their consideration with a progress report to be submitted at the 1979 Interim Meeting and the final report at the 1980 Annual Meeting.

There was nothing of importance regarding National Health Insurance. However, it was interesting that the reference committee reported that: "AMA has not and does not support any program or legislation to nationalize or socialize the health care system in this country."

The House of Delegates voted to drop its participation in the Liaison Committee on Continuing Medical Education (LCCME). There was a long discussion of this problem in the reference committee and on the floor of the House, and as President Tom E. Nesbitt stated, "It's time to bring CME back into the fold of the AMA where it belongs." The AMA will now be the primary accreditor for CME sponsoring organizations.

Regarding chiropractic, the AMA reaffirmed its position that a physician should at all times practice a method of healing founded on a scientific basis, and a physician may refer to another physician, a licensed limited practitioner, or any other provider permitted by law to furnish health care services whenever the physician believes referral will benefit

the patient. It was felt that it was better to note the limitations of chiropractic rather than labeling it as an "unscientific cult."

It was pointed out the need for increasing the AMA membership base, and a report was submitted by the Council on Long Range Planning and Development regarding direct recruitment of members without the necessity of having to go through the state medical societies. The pilot studies are to start on May 1, 1980. Unless there is a significant increase in membership, the House will probably be requested to increase the AMA dues at its meeting in 1980.

One other report of significance was submitted by the Council on Scientific Affairs. This was the adoption of Guidelines for Coronary Bypass Surgery.

I would like, at this time, to commend the Council on its decision to have either the President or President-elect of the county societies attend the Annual Meeting of the House of Delegates held in July of 1979. I believe that the meeting showed them that the AMA is working for you. I would like to invite all members to attend the Interim Meeting of the House of Delegates of the AMA, which will be held in Honolulu in December 1979.

My appreciation to you all for permitting me to be your representative to the House of Delegates of the AMA.

HERBERT Y. H. CHINN, M.D.

## Child Health Planning (Ad Hoc)

**ACTION: Filed.**

This committee met actively the first half of the year to complete the Child Health Care Plan. This Plan presented an overall view of the needs of the child from infancy through adolescence. Child health status, goals and priorities, and implementation plans summarized were submitted to each County Society President, the Hawaii Chapter of the American Academy of Family Physicians and the American Academy of Pediatrics for review and comments. A finalized form was then presented to our Council and adopted.

The Child Health Care Plan has subsequently been submitted to the Statewide Health Coordinating Council and the State Health Planning Office. This will be reviewed by the Subarea Councils and Statewide Health Coordinating Council.

The Child Health Care Plan was taped for television and presented by the Hawaii Medical Association's Public Relations Committee through cablevision. The *Honolulu Star-Bulletin* also featured an article on our efforts. Key members of the Legislature were presented the summarized Plan with emphasis placed on the development of a "Medical home" concept in its presentation. A joint Senate and House Resolution in honor of the International Year of the Child supported basic concepts from our Plan on child health.

There is need to continue to review child health care and assume continued leadership in this area of planning.

#### *Recommendations:*

- (1) The committee continue on an Ad Hoc basis to pursue acceptance of the Plan by the Subarea Councils and State Health Coordinating Council.

CALVIN C. J. SIA, M.D.

## Cancer Commission

**ACTION: Filed.**

The responsibility of the Hawaii Cancer Commission is to establish policy for the administration of the Hawaii Tumor Registry of the Hawaii Medical Association, to act on requests for information from the Registry and to provide registry assistance to hospitals and other agencies who do not have their own registry programs. The Hawaii Tumor Registry provides on-going training for hospital tumor registrars. It is supported by major funds under contracts with the Cancer Center of Hawaii, the Hawaii State Department of Health and the HMA and the Registry is one of a small group of state and/or regional registries belonging to the SEER program of



the National Cancer Institute.

During the year 1979, the HTR will process approximately 200 requests for both general and highly specific cancer data, an increase of nearly 80% in the previous five-year period, with a shortening of response time of approximately 50%. The majority of these requests for data continue to come from the private medical community. A recent quality control study by the National Cancer Institute showed the HTR data to be in conformance with national standards but made important recommendations for continuing quality control checks.

Your Commission has met monthly to enact its required business and is happy to report that the Hawaii Tumor Registry remains an active scientific resource of the HMA, highly regarded nationally and solicits greater continuing use of its increasingly valuable data.

DRAKE W. WILL, M.D.

## Commission on Medical Services

**ACTION: Approved, with the exception of the Fee Survey Committee's recommendation regarding the Relative Value Studies (see Resolution No.1).**

The Commission on Medical Services consists of three committees: (1) Fee Survey, (2) Worker's Compensation and (3) Economic Evaluation and Adjustment Committee. The reports are printed as follows:

WILLIAM W. L. DANG, M.D.  
*Commissioner*

### Fee Survey

This committee has met several times in the past year to review problems associated with the establishment of a new Relative Value Study. The new RVS is ready for publication, but was held up pending clarification of the legality of publishing an RVS. Recently, the American Association of Anesthesiologists has won a court case against the Justice Department and the presiding Judge declared that a Relative Value Study was not price-fixing or fee-setting.

The Fee Survey Committee feels strongly that a new RVS should be published immediately as many members of HMA have asked for this. It appears that the only legal case has been in our favor.

MAURICE W. NICHOLSON, M.D.

### Worker's Compensation

Your Worker's Compensation Committee this year met with members of the Department of Labor and with members of the legislature in an attempt to convert from the present fee schedule to the RVS. I regret to inform everyone, that we have been unsuccessful in this matter, however, we will continue trying. All other matters regarding fees and various problems have been resolved amicably.

BERNARD SCHERMAN, M.D.

### Economic Evaluation and Adjustment

This committee is charged with the responsibility of negotiating fee schedules with various organizations in the community. The committee had no occasion to meet in 1979.

GEORGE GOTO, M.D.

## Commission on Continuing Education

**ACTION: Approved as amended with a vote of commendation for Dr. Nadine Bruce on her CME efforts.**

### *Purpose:*

The purpose of the Committee on Continuing Medical Education is:

- 1) To accredit medical institutions and societies for continuing medical education according to the guidelines of the American Medical Association;

- 2) To establish standards of continuing medical education and encourage the development of high quality programs pertinent to the needs of the local physicians;
- 3) To coordinate and publicize continuing medical education activities within the state of Hawaii; and
- 4) To help physicians fulfill the CME requirements for association membership and state relicensure.

### *Activities:*

The continuing Medical Education Committee met monthly during the past year and accomplished the following tasks:

- 1) The Committee sent a survey team to Hilo Hospital for their continuing medical education resurvey and recommended that Hilo Hospital be accredited with full accreditation for four years.
- 2) The Committee sent survey teams for first-time accreditation visits to a) Kona Hospital, and b) the Maui Federation of Emergency Medicine, Inc. The Committee recommended a two-year provisional accreditation for Kona Hospital and a one-year provisional accreditation for the Maui Federation of Emergency Medicine, Inc.
- 3) The Committee accredited the following programs for Category I with the Hawaii Medical Association as co-sponsor:
  - a) "Overview of Hypertension in Hawaii," sponsored by DHEW-NHBL, Hawaii Department of Health, and Hawaii Heart Association; 3 hours of Category I.
  - b) "Problems in Human Sexuality," sponsored by Lederle Laboratories, Hawaii Pharmaceutical Association, and the Hawaii Nurses Association; 6½ hours of Category I.
  - c) "Substance Abuse," sponsored by the Honolulu County Medical Association; 1 hour of Category I.
  - d) "Current Concepts of Thyroid Disease," sponsored by the Honolulu County Medical Society; 1 hour of Category I.
  - e) "Non-steroidal Anti-inflammatory Agents," sponsored by the Honolulu County Medical Association; 1 hour of Category I.
  - f) "Mini-workshop of Family and Marital Therapy," sponsored by the Hawaii Academy of Family Practice; 11 hours of Category I.
  - g) "Patient Learning Through Effective Use of Media," sponsored by the Media Institute; 20 hours of Category I.
  - h) "Tropical Adventure in Emergency Medicine," sponsored by the Washington Chapter of the American College of Emergency Physicians, the Emergency Medical Service Systems Branch of the Hawaii Department of Health; 25 hours of Category I.

Though the last two programs listed were of excellent educational quality, they had to be cancelled due to lack of registrants.

- 4) The Committee maintained the HMA/CME recordkeeping system and correlated the sending of 1978 CME records without charge to HMA members in March of this year. Currently the recordkeeping system is done by hand and has become very cumbersome due to the voluminous number of CME credits being accumulated by our physicians. It is hoped that the purchase of a computer in the near future by the Hawaii Medical Association will alleviate this problem.
- 5) The Committee processed applications and issued the Physician's Education Certificate to eligible physicians. This is a CME certificate valid for one year and based on one-third of the credit hours required for the AMA Physician's Recognition Award. It was established as an interim measure to assure that Hawaii's physicians would be able to establish proof of individual CME efforts in time to meet the state requirements for relicensure in January of 1980. The certificate has been

issued to 45 physicians, 36 of these are members of the Hawaii Medical Association.

- 6) The Committee and the University of Hawaii School of Medicine, also an accredited institution for Category I, made efforts to strengthen communication in order to better correlate local CME and make available to physicians a wide range of CME activities.
- 7) The Committee has continued to review and keep up-to-date the calendar of CME events in the HAWAII MEDICAL JOURNAL.
- 8) The Committee recommended to the HMA Council that the Hawaii Medical Association join the National Council of State Committees of CME, a new organization formed in an attempt to a) ensure the interests of physicians in private practice, and b) correlate and hopefully make reciprocal the CME policies of the various states. Membership into the National Council was accomplished in June of this year.

#### *Recommendations:*

- (1) That the HMA continue in its present role as an accrediting body for intrastate providers of continuing medical education.
- (2) That the HMA continue to provide yearly printouts of CME records free of charge to its members.
- (3) That the HMA eliminate the Physician's Education Certificate after January, 1980; in the future it will be unnecessary as physicians will have time to accumulate enough CME credits to be eligible for the three-year AMA Physician's Recognition Award.
- (4) That the HMA continue its membership in the National Council of State Committees of CME.
- (5) That the HMA reaffirm its support of mandatory CME.
- (6) That the Hawaii Medical Association support the decision of the American Medical Association to separate from the LCCME and reinstitute its CME accrediting activity.

NADINE C. BRUCE, M.D.  
*Commissioner*

### **Commission on Public Health**

**ACTION:** Approved as amended, with the following recommendations:

- (1) That the Chronic Illness Committee's recommendation relating to the introduction of a bill for home health care insurance be studied further before prior approval of the House of Delegates.
- (2) That negotiations with the Department of Health be based on the Usual, Customary, and Reasonable concept.

The Commission on Public Health consists of the following committees: Cancer, Chronic Illness, Communicable Disease, Crippled Children, Public Safety, School Health, Sports Medicine, and Substance Abuse/Pharmacy. The reports of the committees and recommendations follow.

ROY KUBOYAMA, M.D.  
*Commissioner*

### **Cancer**

The HMA Cancer Committee met on a monthly basis during 1979 focusing on hospice, Cancer Control Program of Hawaii—possible HMA Subcontract, the relocation of the Hawaii Tumor Registry, and discussions with the National Cancer Institute's Site visitors.

The committee, in the coming year, will continue to discuss the possible subcontract between the CCPH and HMA and concerns regarding hospice.

#### *Recommendations:*

- (1) That the position of the HMA Council on the Cancer

Center of Hawaii be included in the proceedings as follows:

#### **POSITION OF THE HAWAII MEDICAL ASSOCIATION ON THE CANCER CENTER OF HAWAII**

The Hawaii Medical Association (HMA) initially supported the development of a cancer research center in Hawaii based on the proposal submitted by the Research Corporation of the University of Hawaii (RCUH) on behalf of the University of Hawaii, in 1973, to the National Cancer Institute in which the cancer research center would be a community organization with the executive committee of the cancer research center to be executive in function and role, i.e., be the policy-making body for the cancer research center and its activities.

The events and direction of the developing cancer research center since that time have created much mistrust on the part of the medical community and the HMA toward the Cancer Center of Hawaii (CCH) and the University. Agreements made in good faith between the HMA and the University have been abrogated by the University.

While the HMA has always been, and always will be, committed to the betterment of cancer diagnosis, treatment, care, and research for the citizens of Hawaii, the abrogation of agreements and understandings by the University makes it impossible for the HMA to support or participate in the Cancer Center of Hawaii and its activities.

Because HMA strongly believes that physicians must be involved in cancer diagnosis, treatment, care, and research, HMA's position with regard to CCH, in no way, precludes the individual physician from becoming involved in cancer activities.

Because the HMA considers the Community Cancer Program of Hawaii (CCPH) a program that is contractually independent from the Cancer Center of Hawaii (CCH), with a separate principal investigator, a separate budget, and reporting directly and only to NCI, the HMA has appointed an official representative to the Executive Committee of the Advisory Cancer Control Council of the CCPH.

- (2) That the HMA monitor existing cancer programs in the State and maintain liaison with those cancer programs which it supports and/or with which it participates.

JOHN KEENAN, M.D.

### **Chronic Illness**

The Committee has had three meetings this year and proposes to meet monthly hereafter.

Initial meetings have consisted of reports concerning relevant activities known to members in the community and tentative planning for future involvement of the Committee.

Reports were received concerning the Gerontology Center, Long Term Care Task Force of the Health and Community Services Council of Hawaii (which is about to produce its final report) and the Long Term Care Task Force of SHPDA (which expects to present its findings by the end of the year).

The Committee delineated the following needs:

- (1) Active interest by Hawaii physicians in Geriatrics. It was suggested that HMA members be polled on their interest in the care of geriatrics patients so that a list for referral purposes may be maintained at HMA.
- (2) The elderly should be maintained for as long as possible in their own homes when ailing, rather than placed summarily in long term care institutions. Many more community resources are needed to facilitate this. (A memorandum to this effect was sent to the Long Term Care Task Force of SHPDA).
- (3) There is a need for more day care centers and for day hospitals for the elderly.
- (4) More education in Geriatrics is needed, in the medical



school, residency training programs and as CME to practicing physicians.

The Committee recommends that these and other concerns be investigated and expanded on by the 1980 Committee.

The Committee is proposing to explore the feasibility of a study on the community care of patients following stroke.

The Chronic Illness Committee strongly and unanimously recommended that the Hawaii Medical Association should consider introducing in the coming legislature a bill to provide for availability of home health care insurance along the lines of the Model Legislation put out by the American Medical Association.

GLADYS C. FRYER, M.D.

## Communicable Disease

The HMA Communicable Disease Committee met on four different occasions in 1979. During the first meeting on January 5, 1979, the committee was informed of the House of Delegates (1978) stand against mandatory premarital rubella testing.

Mr. George Yuen, Director of Health, directed a letter to the Chairman of the Committee regarding this subject. A special meeting was attended by myself and Dr. Kuboyama and explained the HMA's stand against mandatory premarital rubella testing and that voluntary program of premarital rubella testing and immunization would suffice with the decline of rubella susceptible's among child-bearing age women.

However, the 1979 State Legislature enacted (Act 143-1979 SLH) mandatory premarital rubella testing exempting women who are post menopausal, sterilized, or with proof of prior immunization or immunity. This new law stipulates that the test for syphilis along with rubella susceptibility would be required for a marriage license. A referral system of rubella susceptibles to the Department of Health and a five-year sunset clause is to be noted.

A voluntary rubella testing and immunization program was initiated in February 1979, soliciting HMSA's help in publicizing the program. Also, the major instrument of information was decided to be submitted by the Department of Health, since it would reach all of the physicians in the State of Hawaii.

On May 31, 1979, an amendment to Public Health Regulation, Chapter 7, requires Mumps vaccination as a prerequisite for school entrance in the State of Hawaii was proposed.

### Recommendations:

- (1) That the HMA continue to encourage voluntary rubella testing and immunization especially during the pre-adolescent and post-partial rubella susceptibles.
- (2) That HMA inform all physicians' regarding Act 143-1979 SLH, regarding Mandatory Premarital Rubella Testing.
- (3) That mumps vaccination be included as a prerequisite for school entrance.

DENIS J. FU, M.D.

## Crippled Children

The Crippled Children Committee has met twice during the past year. At the first meeting on February 22, discussion focused on budgetary cuts faced by the Crippled Children Branch of the Department of Health by using funds for severely handicapping conditions which require surgical procedures such as collar button tubes, tympanoplasties, mastoidectomy, etc., or for those requiring hearing aids. The Committee concurred with a proposal presented by Dr. Wright of the CCB-DOH entitled "Communication Disorder/Surgical Ear Program."

At the meeting on June 1, Dr. Wright discussed hourly rates for specialist consultants in the Health Department. The Committee agreed that an increase in the hourly rate for

specialist consultants would be appropriate; a recommendation letter was sent to Mr. George Yuen of the Department of Health, but there has been no response at present.

### Recommendations:

- (1) That the Crippled Children Committee follow-up on the fee schedules and coordinate with various agencies regarding services for the Crippled Children Branch.

D. V. REDDY, M.D.

## Public Safety

The Public Safety Committee had no meeting during 1978-79. Our opinions on several legislative matters were requested and this was fulfilled without a meeting of the whole group.

Even though the Committee is not very active at present, I feel that it potentially fills an important place and should be continued.

TRUETT V. BENNETT, M.D.

## School Health

The HMA School Health Committee and School Health Services Branch of the Department of Health worked to facilitate school-to-physician communications by clarifying school health policies and procedures in a loose-leaf guideline to be mailed to HMA physicians and as many other primary physicians as the budget would allow. Enclosed in the first mailing are to be:

- 1) The Epidemiology Branch's list of excludable diseases.
- 2) A directory of school nurse locations and telephone numbers.
- 3) The procedure for medication request form.
- 4) The policy on tuberculosis clearance.
- 5) The basic immunization requirement for all new school enterers.
- 6) Scoliosis screening reminder.

A recommended list of conditions disqualifying school children from contact and non-contact sports met with much discussion in both the School Health and Sports Medicine Committees and was deleted from the guideline pending further clarification from the AMA and the American Academy of Pediatrics.

### Recommendations:

- (1) The Committee recommends that the HMA support the school health manual and provide those monies necessary to keep it updated for the next year.
- (2) That the School Health Manual be made available to non-HMA members at a nominal sum.

ANN B. HO YEE, M.D.

## Sports Medicine

The Sports Medicine Committee met regularly once a month during the year. The Sports Medicine Seminar was held on May 4, 1979 at McKinley High School's Multi-Purpose Room and organized by Dr. Gerald Mayfield. It was attended by 105 participants and was very well received. In response to the questionnaire that was distributed, participants felt that a whole day seminar held on the weekend would be more desirable.

A main concern of the Committee was the problem of lack of communication between the physician and the coaches when an injured athlete would return to the sport. The Committee met with the Department of Education and a School Health Physician of the Department of Health and expressed their concerns. The Department of Education promised to look into the matter and devise a form to be used for this purpose.

### Recommendations:

- (1) That the Sports Medicine Seminar be held at some

convenient time prior to the opening of the first football practice next year with a morning session focusing on talks and the afternoon session focusing on workshops for coaches and trainers.

- (2) That the Hawaii Medical Association identify appropriate representatives to meet with the representatives from the University of Hawaii and from the *Honolulu Advertiser* to review their methodology of reporting injured athletes and that an attempt be made by all interested individuals to utilize one system.
- (3) That the neighbor islands be included in the seminar by sending a representative from the Committee to the neighbor islands to consult with coaches, athletic officials, etc.
- (4) That the Sports Medicine Committee's activities not exceed its budget of \$500 for the year.

BAL RAJ MEHTA, M.D.

## Substance Abuse/Pharmacy

The Substance Abuse/Pharmacy Committee met seven times during the past year and completed the following activities:

- 1) The Committee reviewed the proposed drug formulary prepared for the Hawaii Medicaid Program and provided testimonies as well as direct input to the DSSH. Several areas of concern were brought to their attention, and this included the infringement upon the physicians' right to prescribe, the non-coverage of vitamin therapy when needed, and restriction on certain useful and less costly barbiturates.
- 2) In cooperation with the Legislative Committee, members of the Committee participated in lobbying effort of several important bills by providing testimonies and supporting data to key legislators. Specifically, the HMA successfully required the necessary safeguards be incorporated in the generic drug substitution bill and opposed the legalization of marijuana and heroin for therapeutic use (H.B. 256 and S.B. 232). Other bills that received the Committee's endorsement included increase funding for alcohol treatment and food and drug coupons for the elderly.
- 3) The Committee also provided suggestions regarding revision of the Public Health Regulation related to controlled substances through direct communication with the Diversion Investigation Unit Office.
- 4) The Committee had an opportunity to meet with Mr. James Nakada, a key FDA official, who was able to answer questions on the activity and accomplishment of FDA.
- 5) The Committee through its members continued to participate in reviewing the substance abuse treatment facilities of the state through membership in the Hawaii State Commission on Substance Abuse. The Commission in turn worked very closely with the Drug and Alcohol Branch of the State Department of Health.
- 6) Finally, a demonstration project from the UH School of Public Health in providing medication cards for elderly patients throughout the state was reviewed. The Committee endorsed the concept and expected to assist in implementation, when funding is available.

### Recommendations:

- (1) It is recommended that the Committee continue its activity in the above areas for the following year.

JAMES LUMENG, M.D.

## Commission on Health Service and Care

### ACTION: Approved as amended.

The Commission on Health Service and Care involves the work of four committees: Community Health Care, Health Manpower, Disaster, and Health Care Costs.

As usual, there is a sense of some inadequacy in terms of what Hawaii Medical Association can muster and deliver in these critical areas of medical care planning.

Nevertheless, physicians in the Hawaii Medical Association continue to be held in esteem by others in the community, and our contributions and input remain valued and trusted.

The State Health Plan continues to demonstrate our contributions. The Manpower Task Force for the State Health Plan has appointed the chairman of our manpower committee to head the task force. The Commissioner has been elected to chair the Governor's Advisory Committee for the Functional Plan for Health for the State General Plan.

As pointed out by the Chairman of the Medical Care Costs Committee much more can be done, not only for this committee, but on behalf of this demanding area of dealing with the multiple community agencies and organizations involved with planning for health services and care. Parenthetically, it should be again pointed out that physicians in fee-for-service private practice find it difficult to attend the many meetings during the day in which most of these community agencies and organizations meet.

DONALD F. B. CHAR, M.D.  
*Commissioner*

## Community Health Care

The Community Health Care Committee met three times and the subcommittees met four times. Activities centered primarily on SHPDA and its relation to the Hawaii Medical Association. The Committee assisted SHPDA in amending the definition of an "organized ambulatory health care facility" in the Certificate of Need process.

The Committee with the assistance of Commissioner Donald Char, M.D., composed "Hawaii Medical Association's Reactions to the Hawaii State Health Plan for 1979" and sent these comments to Mr. James Swenson, Administrator of SHPDA.

The Committee voted to recommend to the HMA Council support for Mr. James Swenson's reappointment as SHPDA Administrator.

Other topics discussed at committee meetings included a University of Hawaii School of Nursing grant application, the Child Health Care Plan, the Plan for Wellness, and the Plan for High Risk Perinatal Health Services.

The HMA staff composed a list of frequently asked questions by patients calling the Hawaii Medical Association. The list was referred to the Public Relations Committee.

There are no specific budget requests.

### Recommendations:

- (1) Close cooperation and monitoring of activities of SHPDA.
- (2) Promoting physician interest and activity and provide input into current State organizations such as SHCC, SACs, and SHPDA, and that
- (3) Health care planning may involve many areas of endeavor, and it may be more useful to concentrate the efforts of the Committee on HMA inter-relationships with these governmental agencies and to select only a few other projects.

STANLEY CHUNG, M.D.

## Disaster

The HMA Disaster Committee jointly met with the HCMS Disaster Committee, chaired by Dr. C. K. Lum, on several occasions to develop a standardized disaster triage tag with input received from the city, state, military, hospitals, and private agencies. Arrangements are also being made by the HMA & HCMS Disaster Committees for the Regional Hospital Medical Disaster Exercise.

### Recommendations:

- (1) That the Disaster Committee continue meeting jointly with the Honolulu County Medical Society's Disaster



Committee, and assist other county societies upon request.

LEONARD HOWARD, M.D.

## Health Care Costs

An attempt was made to combine the HMA Health Care Costs Committee with the physician's subcommittee of the Hawaii Voluntary Effort Committee. In addition to the HMA representatives on the Committee, each hospital was invited to send a representative to the committee. This approach met limited success.

The committee met twice to explore ways of physician involvement in cost containment. As a result, a brochure suggesting ways of medical cost control adapted from a similar effort in Texas, was developed by HMA staff and sent to physicians in Hawaii.

There is a continued need for cost containment but this committee should be chaired by someone with the time and ability to generate enthusiasm among Hawaii physicians. This is not an easy task.

MARION L. HANLON, M.D.

## Health Manpower

This Committee has resumed regular monthly meetings. In view of its recent quiescence, however, the current membership initially sought to define its objectives as follows:

1. To identify the more pertinent health manpower issues in Hawaii.
2. To assemble health manpower data and statistics.
3. To evaluate supply, need, demand, distribution, and organization of health manpower.
4. To recommend health manpower policy for HMA consideration and action.

Among the major issues we have begun to address are the following:

1. Mounting public and legislative concern over issues of health manpower distribution and supply, especially alleged excessive numbers of physicians.
2. Need to more fully evaluate impact of the major local source of physician supply, i.e., the University of Hawaii School of Medicine.
3. Threat of regulation of physician licensure via SHPDA Certificate-of-Need process, or some similar mechanism.
4. Lack of an adequate and valid data-base for rational manpower policy determination.
5. Need to enhance more effective working relationships between organized medicine and external agencies such as the State Health Planning and Development Agency, State Department of Health, Board of Regulatory Agencies, University of Hawaii, Hawaii Nurses Association, Hawaii Academy of Physicians' Assistants, etc.

Within this context, major Committee activities include the following:

1. Three manpower groups have been targeted for consideration, namely, physicians, nurses, and physicians' assistants.
2. Legislative policy recommendations are to be formulated concerning regulation of physician licensure, nurse practitioners and their potential independent practice, conjoint practice (MD-RN), and licensure of physicians' assistants.
3. Initial consideration was given to independent development of a complete state-wide health manpower data-base by HMA. However, the scope, required expertise, and cost of such a project convinced us that a more realistic endeavor would be to participate quite actively in the development of the SHPDA manpower data-base, which will be utilized in governmental planning. Currently, the most valid data (which is quite compatible with AMA data) is available to SHPDA from HMSA. These data will be refined, as necessary, based on information derived from the recent Department of Health survey. In the long range, a data-base is to be developed by the Board of Regulatory Agencies in collaboration with HMA.

4. Closer working relationship with SHPDA has been pursued by means of joint meeting with SHPDA officials and more frequent communication. Initial success of this effort is reflected perhaps in the recent selection of the Committee chairman to chair the SHPDA Task Force on Health Manpower.
5. Closer working relationship with the nursing profession has been pursued by means of a series of joint meetings with HNA officials and other nursing leaders. In addition to better communication, anticipated outcomes include reactivation of the Joint Practice Commission, and conjoint preparation of legislative proposals.
6. Closer working relationship with physicians' assistants will be pursued in the near future by means of joint meetings with representatives of the Hawaii Academy of Physicians' Assistants. Hopefully, a legislative proposal concerning licensure will emerge from these discussions.
7. Closer working relationship with the University of Hawaii School of Medicine will be pursued in the near future by means of joint meetings with the Dean and other officials. Hopefully, the manpower implications of future planning by the School can be clarified.

### Recommendations:

- (1) That HMA strive vigorously, through a network of community relationships, to assert provider leadership in the development of a rational health manpower policy for Hawaii.
- (2) That HMA oppose at this time the governmental regulation of the number of physicians allowed to practice in Hawaii.
- (3) That HMA re-affirms its commitment to meaningful collaboration with our colleagues in nursing.

GEORGE C. BOLIAN, M.D.

## Resolution No. 1

### ACTION: Not Adopted

Re: Publication of Relative Value Studies

Be it *resolved* that the Hawaii Medical Association publish a new Relative Value Study.

MAURICE W. NICHOLSON, M.D.

## Resolution No. 8

**ACTION: Adopted as amended with the recommendation that an ad hoc committee be formed under the Bureau of Research and Planning and that the committee report to the Council on a monthly basis.**

Re: Ad Hoc Committee to Consider Establishment of a Hawaii Health Corporation

WHEREAS, public and government concern about the quality and cost of health care is acute, and

WHEREAS, any inadequacy in our efforts to control costs, conduct peer review, initiate and evaluate new health care delivery systems, etc., can only be expected to lead to increased legislative efforts to introduce N.H.F. or to grant more government control over the medical profession, and

WHEREAS, the official activities related to those areas, benefiting the entire medical profession and all our patients are carried out by a limited number of HMA and County Medical Society members without compensation and to the detriment of those own practices, families, and health, and

WHEREAS, our competent HMA and County Medical Society staffs are already overburdened in meeting current responsibilities, therefore be it

*Resolved*, that HMA appoint an ad hoc Committee to:

1. Consider the establishment of a Hawaii Health Corporation to:
  - a. accumulate and distribute funds for its own operation and to hospitals and to state and county medical associations for appropriate designated functions

- benefiting the entire profession and our patients (e.g., Hospital Chiefs of Staff, Medical Association Presidents, Members of the Council, Board of Governors, Peer Review Committees, etc.)
- b. coordinate efforts in cost containment,
- c. assure adequate peer review mechanisms and CME within hospitals,
- d. investigate, initiate and evaluate alternate systems of health care,
- e. encourage or initiate appropriate legislation,
- 2. recommend possible methods of financing the Health Corporation,
- 3. and to report its recommendations to the next House of Delegates.

NEAL E. WINN

## Reference Committee on Miscellaneous Business

### Commission on Internal Affairs

**ACTION: Approved as amended with the recommendation that the Bylaws Committee prepare the suggested amendments to the bylaws for submission to the 1980 House of Delegates.**

The Commission on Internal Affairs consists of three committees: Arrangements, Bylaws, and Publications. The Bylaws Committee did not meet in 1979. The reports of the other two committees are printed below:

NEAL E. WINN, M.D.  
*Commissioner*

### Arrangements

This committee met several times during the year to arrange the 123rd HMA Annual Meeting at the Ilikai Hotel, again held in conjunction with the AMA Regional CME meeting. HMA was responsible for the sports tournaments—golf, ping-pong, tennis, and skin diving; the House of Delegates meeting; exhibits; banquet; and on-site registration. The AMA, with the help from Dr. Herbert Uemura, the HMA Liaison Physician appointed by our President Dr. Goto to serve on the AMA Council on Continuing Physician Education, was responsible for coordinating the scientific program. As in previous years, HMA was responsible for the special workshops and this year we had the Special Seminar on Skin Cancer on Monday night and the Special Medical Collection Management Course for medical assistants on Tuesday afternoon. The HMA again hosted the popular cocktail party to welcome the visiting registrants and guests on Monday evening at the Ilikai. During this cocktail party it was decided to have the exhibitors' booths open enabling them to get maximum exposure. (The Arrangements Committee met with representatives earlier in the year to discuss increasing complaints regarding diminishing attendance by physicians at their booths.) For the first time in many years, the booths will be open only three mornings of the five day meeting.

The AMA/CME postgraduate courses were scheduled every morning, Monday through Friday, with breakfast served to participants. Registration for the CME program was \$25 for all AMA physicians with the fee waived for HMA members and house staff physicians. The CME course tuitions were separate and paid directly to AMA.

The House of Delegates met on Monday and Wednesday afternoons. The Sportsmen's Night Party was held on Thursday at the Kanraku Tea House, and the annual banquet climaxed the meeting on Friday evening.

Work has begun on the 1980 annual meeting, and AMA has expressed interest in continuing the CME program here. A tentative week in October is being held at the Ilikai, but other hotels are being checked.

#### Recommendations:

- (1) That the HMA plan on having another joint meeting

with the AMA in 1981.

- (2) That the Arrangements Committee be allowed to continue planning and making arrangements for the 1980 annual meeting with final approval by the council.
- (3) That the Committee be allowed to make plans for future meetings, with final approval by the council, because of space limitations at the major hotels.

NEAL E. WINN, M.D.

### Bylaws

The meeting of the Bylaws Committee was held during 1979 since there was no legislation requested by the Council and a general review of the bylaws is not required in this calendar year.

GLADYS C. FRYER, M.D.

In accordance with the HMA Bylaws, the HMA Officers met for their annual review of the bylaws. It is recommended that the following chapters be reviewed for possible changes and that the House of Delegates instruct the Bylaws Committee to consider these changes and submit them in the form of amendments to the bylaws at the next House of Delegates meeting in 1980.

Chapter 4.02: Special representatives: A seat shall be provided in the House of Delegates for one delegate elected by the *student body of the University of Hawaii School of Medicine. The elected member who shall be accorded the privilege of the floor with a vote must be a medical student member of the Hawaii Medical Association.*

*A seat shall be provided in the House of Delegates for one delegate elected by the resident physicians in Hawaii who shall be accorded the privilege of the floor with a vote. The elected member must be a resident physician member of the Hawaii Medical Association.*

These representatives shall be members of a component medical society and the Association.

Chapter 5.033 Review HMA's financial support to the medical library by deleting the word "shall" and insert the word "may" and delete the words "at least once a year."

Chapter 5.06 Update "Health and Welfare Department" to "Department of Health" and "Department of Social Services and Housing."

Chapter 6.031 Amend this section to state that the Association "may" instead of "shall" establish a scientific meeting, and add "in conjunction with other organizations such as the AMA, etc."

The Bylaws Committee should also add to the bylaws, changes that were made at previous meetings:

- (1) non-member physicians and lay persons are allowed to sit as a voting member of commissions, boards and committees of the HMA as long as 51% of those members are HMA members and with permission of the Council who shall designate whether the member is to be a voting or non-voting member. (Resolution 3, 1978 House of Delegates.)
- (2) Physicians in their first year of practice would be granted one-half dues for their first year of practice in conformance with AMA action. Council is to determine guidelines.

GEORGE GOTO, M.D.

### Publications

**ACTION: Approved.**

The Publications Committee met one time, March 1, 1979. Other meetings would have been scheduled "on call" should crises have arisen. None did, so none were.

The HAWAII MEDICAL JOURNAL is issued monthly and is



holding its own with respect to finances and articles being submitted.

A new roster will be printed at the end of 1979 and again in 1980, the final year of a three-year contract. The committee should evaluate the Roster contract in 1980 and present recommendations to the 1980 House of Delegates.

#### *Recommendations:*

- (1) That the Journal subscription rate remain \$10.00/year, \$6.00 for students.
- (2) That HARRY L. ARNOLD be reappointed as Editor.

DORIS R. JASINSKI, M.D.

### **Editor, Hawaii Medical Journal**

#### **ACTION: Approved.**

The HAWAII MEDICAL JOURNAL has continued to be published in the same format during the past year; in calendar 1978 it ran to 416 pages, with a typical issue at 32 pages, with about 13 pages of advertising. It has been possible to publish 2 to 4 articles in each issue, and the features of editorials, the Clinical Pathologist's Easy Chair (written by Francis Fukunaga, M.D.), Notes & News (written by Henry Yokoyama, M.D.), HMA Newsletter (by Jon Won), Hawaii Academy of Family Physicians Newsletter (by J.I.F. Reppun, M.D.), Leadership Report (by Jon Won), Continuing Medical Education Report, HMA Council meeting minutes, Book Reviews, and the Proceedings of the House of Delegates, have all been continued.

We have again been invited, even urged, to merge the HAWAII MEDICAL JOURNAL with WESTERN MEDICINE, and gave the suggestion the most serious consideration. We decided to retain our individual identity instead, as long as it remains fiscally feasible.

Dr. Reppun resigned as Associate Editor, and has been replaced by John M. Corboy, M.D. His principal task is writing editorials. Doris Jasinski, M.D., has continued to do a fine job as Assistant Editor, in charge of manuscript editing. Henry Yokoyama has continued to function capably as News Editor and provide us with almost the only comment we receive from readers on any aspect of the journals contents: complaints about his jokes. They are balanced by compliments, but they are often justified, and we have responded by a weeding operation whenever opportunity presents.

Articles have been submitted in sufficient amount to keep us just 2 or 3 issues ahead of the current one, and we still only reject outright about one in ten, and return one or two for minor revision or condensation.

It is recommended that we continue to publish the HAWAII MEDICAL JOURNAL monthly as during the past year, as long as our capable Executive Editor, Paul Steward, is able to produce it on a financially manageable basis.

HARRY L. ARNOLD, JR., M.D.

### **Honolulu County Medical Society**

#### **ACTION: Approved.**

The 1979 year that is drawing to a close has been a contemplative and quiet year spent in consolidating the varied programs of the Honolulu County Medical Society.

This was the first year where specialty society representatives composed the Board of Governors with several members representing the "at large" category. It has been a stimulating and informative experience for the officers and the Board with a high rate of attendance at each meeting.

The Peer Review Committee along with its associated Medical Practice, Medical Plans and Fees, and Utilization Review Committees continue to function in their capable and effective manner. A new ad hoc committee on the Impaired Physician was formed this year and has been quite effective in assisting several physicians already.

The Public Relations Committee, although sorely missing Dr. Felix Lafferty, has nevertheless continued to produce the Hawaii Health Tip Newsletter. The Community Action

Committee will sponsor a Seat Belt Week in conjunction with the local American Academy of Pediatrics Chapter as part of the International Year of the Child activities. The Membership and Membership Recruitment Committees have been active, focusing on the problems of recruiting and maintaining membership by holding meetings with physicians, residents, and medical students.

The Program Committee has planned several membership dinner meetings with spouses which were held at various restaurants with guest speakers making presentations on a variety of subjects. The committee also experimented with the idea of holding Board of Governors meetings just prior to a regular membership meeting, serving a light supper to board members as well as members attending the meeting, which proved highly successful in getting more members out to such meetings.

WALTER W. Y. CHANG, M.D.

### **Maui County Medical Society**

#### **ACTION: Approved.**

The Maui County Medical Society has had an active year, having met every month without exception. Guest Speakers so far have included AMA Past President Dr. Donovan Ward in January, HMA President Dr. George Goto and HMA Executive Director Mr. Jon Won in February, Maui Mayor Elmer Carvalho in March, anesthesiologist-cum-investment counselor Dr. Kenneth McCollum in April, SHPDA Administrator Rev. James Swenson in May, attorney and estate planner Mr. Thomas Bodden in June, Maui Mental Health Service Director Dr. Edgar Auerwald in July, U.S. Congressman Cecil Heftel in August, and Maui EMS Program Director Dr. Charles Mitchell in September. Monthly meetings have already been scheduled for the remainder of the year. These monthly society meetings have also served as a forum for discussion of issues affecting the practice of Medicine at a local level. Maui physicians have also been made aware of current legislative issues. For example, earlier this year, when Hawaii's ophthalmologists and optometrists did not see eye to eye regarding the proposed use of "diagnostic drugs" by optometrists. The Maui County Medical Society contacted all six Maui Legislators, urging them in the name of public safety to oppose any bill that would allow non-physicians to practice medicine.

Membership in the Maui County Medical Society has grown to the point that we are now the second largest county medical society in the state. However, the potential for further membership growth is limited by the fact that the majority of psychiatrists and emergency physicians on Maui object to the concept of unified membership at the county, state and national levels, and consequently have not joined the county society. The Society has continued to support the "Unit Rule" of mandatory AMA and HMA membership.

BEN K. AZMAN, M.D.

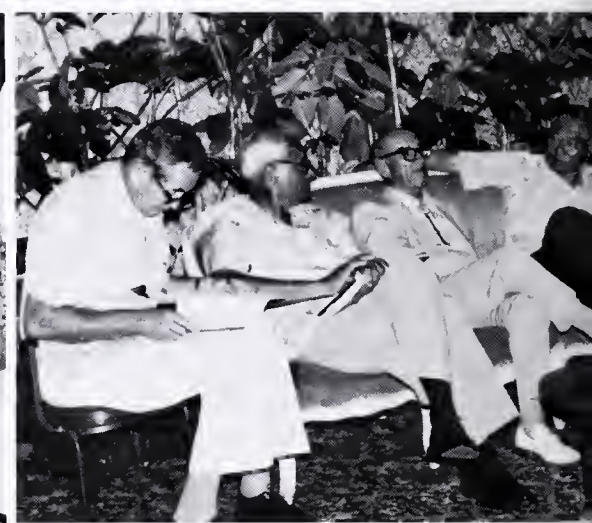
### **Hawaii County Medical Society**

#### **ACTION: Approved.**

One of the main concerns of the Society has been membership which had been on the decline during the last few years. The membership committee has attempted to solicit members on an individual basis as well as frequently inviting non-members to our meetings. Contact had been made on several occasions to increase our membership in the Kona area. Happily the Society has had an increase in membership this year, a trend I hope continues. Major reasons given for not joining were the building plan, high dues and the unit rule.

Physicians have continued to give generously of their free time to support youth athletic programs in the community. These programs could not function without their support. Awareness House has been contacted in regard to physician volunteers doing physical examinations on patients with drug related problems.











A committee to aid the impaired physician has been formed. Useful literature has been requested and received from the Mental Health Department of the American Medical Association. There has been much enthusiasm and interest in this committee.

For myself, I have enjoyed the year, working on the county and state level as well as representing Hawaii County at the Annual AMA meeting in Chicago. I've gained a greater appreciation and pride in our organization as well as a greater respect for the many talented and outstanding persons dedicated to improve health conditions and lifestyle in our society.

ALEX. SCOTT K. MILES, M.D.

Commission on Peer Review

ACTION: Approved.

The Committees comprising this Commission are: the Maternal and Perinatal Mortality Study Committee under the chairmanship of Dr. Lockwood Young; the Professional Liability Committee, whose chairman is Dr. Bernard Fong; and the Peer Review Committee, the chairman of which is Dr. Chew Mung Lum.

The Maternal and Perinatal Mortality Study Committee met regularly to review maternal death cases and those perinatal death cases referred to it by its Steering Committee, which reviewed a total of 51 cases. The main committee reviewed 3 maternal deaths and 27 perinatal deaths this past year.

The Professional Liability Committee did not meet this year. The chairman was able to take care of the few inquiries by telephone. It is the opinion of the chairman that because of the recent change in availability of insurance companies offering malpractice coverage, and the continued functioning of the state conciliation panels, this HMA committee is no longer necessary.

The Peer Review Committee did not meet this year but information is being obtained from the county societies to review peer review bylaws.

Recommendations:

- (1) That the Professional Liability Committee be discontinued as it no longer has a role to fulfill.

ANN B. CATTS, M.D.  
Commissioner

Commission on Legislation

ACTION: Approved as amended.

Responsibilities of the Legislative Committee under the Legislation Commission are to interact with government through the legislative process on behalf of physicians and their patients toward the goal of improved medical care. This includes initiation of bills, the study of bills as submitted, testimony at public hearings, and lobbying for or against proposed legislation. Properly it includes establishment of legislative friends and conduits sympathetic to and cognizant of our viewpoint.

The major issues confronted were:

ISSUE	END RESULT
Minor's Consent	Passed
Optometrists using drugs	Will resurface in 1980
	Routed by hard work
Generic Drug Law	Vetoed by Governor on technicality
Patient's Rights (Psychiatric Care)	Died in Committee,
Chiropractic/3rd party reimbursement	Study is underway by DOH
Medicaid Profile	Died in Committee
Revision & Budget	Budget slashed to 1975
	Profile in Easter night conference committee
EMS Program	Budget continued for eight months
Act 219 revisions	Died in committee

HAPI Corpus Reduction	Passed, bringing HAPI to life
Certificate of Need	Passed. Exempts physician offices deemed not to have a significant impact on the health care system
Brain death	Passed. Designates the attending physician as the sole individual to determine death and deletes requirement for neurologist or neurosurgeon
Drug labels	Passed. Requires the labeling of drugs to include the name, strength and quantity of drug and eliminates phrase "Take As Directed."
Rubella	Passed. Requires marriage license applicants be tested for rubella.

Additionally, discussions of national health insurance proposals were held and views communicated to our congressional representative.

The additional help of Judge Kazuhisa Abe as Legislative Counsel was utilized but with less impact than in the past due to many new legislators, the mood of the legislature, failure of the commissioner to best utilize his service, and the fact that issues at stake were less "legal" and more "social" in nature.

An active ad hoc committee on medical malpractice, chaired by Dr. Philip Hellreich, held numerous meetings pursuing the issue of the cost of malpractice insurance in this state and recommends hiring legal counsel to pursue a public hearing by the insurance commissioner into the rate setting process at an estimated cost of \$100,000.

The battle of the ophthalmologists against the attempted revision of the optometry act to permit optometrists to practice medicine should be applauded and viewed by the society as the kind of effort that can be successful at the legislature and should characterize our response to other problem issues.

The Commissioner wishes to make several recommendations in our approach to the legislative process for reasons that include:

- a) The workload is massive and increasing,
- b) It seems everyone wants to plan, regulate, or control the health care industry or want a piece of the action. In short, we are in a war for the survival of the free enterprise health care system,
- c) Our viewpoints are not well perceived or understood,
- d) We lack sufficient friends and conduits in both Federal and State Legislation.

Recommendations:

- (1) That it shall be HMA policy that all standing committees of the HMA to bear responsibility for legislative matters pertinent to their areas of concern and activity. Oversight and coordination of such legislative activity shall be carried out by the Legislative Committee.
- (2) That we budget for and employ a full-time lobbyist for about six months annually surrounding the legislative session: Estimated cost—\$12-\$15,000. An adequate personality has not yet been found,
- (3) That legal counsel be utilized on a piece-work-as-needed basis.

E. LEE SIMMONS, M.D.,  
Commissioner

Medical Malpractice Law, Ad Hoc

ACTION: Approved as amended.

The purpose of this committee was to review the malpractice situation in this State and to:



1. Determine if any changes or amendments to Act 219 are needed,
2. Review the malpractice situation in this State and to determine why malpractice rates remain high in Hawaii and,
3. To determine what we can do to lower malpractice rates and to encourage competition in the insurance industry insofar as the provision of medical practice coverage is concerned.

Our Committee did the following in order to pursue the above goals:

1. Met with the State Insurance Commissioner to discuss what criteria this State Regulatory Agency uses to set medical malpractice insurance rates in the State of Hawaii,
2. Met with Mr. Singrey of Argonaut to discuss the possibility of lower rates in the future,
3. Introduced resolutions in both houses of the State Legislature to provide for periodic payments of the medical care portion of malpractice awards exceeding \$10,000, and to deduct collateral source payments from total to be paid patient by Insurance Companies Patients Compensation Fund,
4. Attorney James Kreuger was sent to Philadelphia to review legal actions taken in the State of Pennsylvania against Argonaut to help determine if legal action should be taken against Argonaut in order to force Argonaut to justify its correct rate structure,
5. Met with Mr. Paul Brown of United Independent Insurance Agencies, Inc., in which he discussed that the agency could offer medical practice insurance at rates 13 percent below that of Argonaut's correct rate structure, and
6. Reviewed the Annual Report of Activities of the Medical Conciliation Panel.

#### *Recommendations:*

- (1) The Committee should be continued on an ad hoc basis.

PHILIP HELLREICH, M.D.

## **Medicaid, Ad Hoc**

**ACTION: Approved with the recommendation that the committee continue to function.**

The Medicaid Committee met several times prior to the 1979 Legislative Session. It was agreed by the Committee members that amendments to the 1976 Medicaid Law should be pursued namely adjusting the professional fees up to the 1978 profiles based on usual and customary fees up to the 75th percentile. Because of the new members in the Senate and the House of Representatives in the 1979 Legislative Session, members of the various House and Senate Committees were not chosen until a few days prior to the beginning of the 1979 Legislative Session.

The Department of Social Services proposed amendments to the 1976 Law which would be interpreted more accurately, according to them, as to who is responsible for the professional fees adjustment. Members of the HMA during discussions with the Conference Committee brought out the fact that the 1976 statute should not be deleted since 1979 was the first time that the fee adjustment was to be made by the Department of Social Services.

However, this was not considered and as of 1979, the professional fees are at the same level of 1975. There is also a change in the law which states that the legislature shall determine how much the professional service fees shall be. It was pointed out that with all the decisions that the legislature must make in a short period of time, there will not be adequate time for the legislature to fully realize the problems of the Medicaid recipients; however, this was not accepted and the amendment passed.

For the future, it will be important to work with the specialty groups and the DSS recipients and again demonstrate to the legislature that it is the responsibility of the State

and the Federal Government to provide health care for Medicaid recipients and that the professionals cannot bear the burden of underwriting the program.

ROY KUBOYAMA, M.D.

## **Self Insurance, Ad Hoc**

**ACTION: Approved.**

The Ad Hoc Self-Insurance Committee met twice this year and once with the Ad Hoc Committee on Malpractice Insurance. In June, a meeting had been scheduled with key people from a California based insurance company, but because of a communication misunderstanding that meeting was canceled. There is a need to study further the development of a physician-owned company and further evaluate new alternatives or reevaluate older ones.

#### *Recommendations:*

That this committee continue to exist and meet as needed.

MAURICE W. NICHOLSON, M.D.

## **Emerging Medical, Moral, and Legal Concerns (Ad Hoc)**

**ACTION: Approved with the recommendation that the Committee be continued as a resource committee for the medical community and the community at large.**

This committee did not meet this year.

The requirement for a neurosurgeon or neurologist to see a patient in consultation before brain death could be pronounced was deleted from the State law.

If this committee is to continue in existence, its purpose must be redefined.

ARNOLD W. SIEMSEN, M.D.

## **Resolution No. 3**

**ACTION: Adopted as amended with the recommendation that it be referred to an ad hoc committee appointed by the President and which is responsible to the Council.**

Re: Petition for Medical Malpractice Insurance Rate Review Hearing

WHEREAS, malpractice insurance premiums in the State of Hawaii are comparable to those of states with a far worse malpractice record than ours in terms of losses incurred per practicing physician, and

WHEREAS, the malpractice situation in Hawaii has improved since the creation of the Medical Conciliation Panel and the Patients Compensation Fund, and

WHEREAS, Argonaut Insurance Company has premiums earned of \$17,006,480 and losses paid of \$2,269,669 from 1975-1978, and

WHEREAS, Argonaut showed negative losses incurred of \$141,949 in 1977, \$2,716,083 in 1978, and \$801,794 for the years 1975-1978 which strongly suggests that Argonaut greatly over-reserved and thereby exaggerated the rates required to provide malpractice coverage, and

WHEREAS, the Insurance Commissioner refused to permit Financial Security Life Insurance Company, Ltd., of Hawaii to write medical malpractice insurance at a rate of 13 percent below those of Argonaut's current rates and therefore has inhibited competition in this field, and

WHEREAS, a suit filed by the Pennsylvania Medical Crisis Committee representing 2,000 physicians in medical corporations in the State of Pennsylvania revealed in 1976 that Argonaut had over-reserved 137 of 139 closed malpractice cases in Pennsylvania and therefore overstated the rates requested to provide coverage, and

WHEREAS, suits filed in Pennsylvania saved Pennsylvania physicians \$7,500,000 in malpractice premium rates that had been requested by Argonaut but which were then

denied by the Insurance Commissioner following hearings, and

WHEREAS, Attorney William Taylor who filed suit for the Pennsylvania Medical Malpractice Crisis Committee estimates that to engage in the full discovery and the rate hearing required to oppose the Commission, legal expenses of about \$100,000 would be incurred to bring the matter through a full hearing before the regulatory authorities, therefore be it

*Resolved*, that the HMA, through its appropriate committee(s) encourage and sponsor the formation of a Malpractice Insurance Crisis Committee of interested physicians, physician groups, hospitals and other facilities to petition for a complete rate review hearing before the Hawaii Insurance Commission, and to raise funds as needed for such petition.

PHILIP HELLREICH, M.D.

Resolution No. 4

ACTION: Adopted.

Re: Equitable Risk Classification in Medical Liability Premiums

WHEREAS, the risk of medical malpractice action to any particular category of physicians is variable and dynamic, requiring frequent study and updating of loss experience data, and

WHEREAS, there is general agreement that medical liability insurance premiums should reflect the actual cost and risk of providing insurance to any particular category or group, therefore be it

*Resolved*, that Hawaii Medical Association supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing the insurance to each individual group or category.

EUGENE G. C. WONG, M.D.

Commission on Interprofessional and Public Affairs

ACTION: Approved.

The commission on Interprofessional and Public Affairs consists of two committees: Public Affairs which also includes the Tel-Med functions, and Television-Radio. The reports of these committees are listed below:

PHILLIP I. MCNAMEE, M.D.  
Commissioner

Public Affairs

The committee met monthly. A number of projects were undertaken and completed. The committee:

- (1) Jointly sponsored with Hawaii Newspaper Agency a Public Forum "Living With Cancer."
- (2) Provided physicians as judges for the Hawaiian Science and Engineering Fair. Also provided multiple prizes totaling \$400.
- (3) Selected the HMA Physician of the Year (Robins Award).
- (4) Selected four recipients for the HMA Awards for Medical Reporting.
- (5) Developed the concept of a Health Fair which will celebrate the 125th anniversary of the HMA in 1981.

The budget request for Public Affairs, TV-Radio and Tel-Med is listed below:

Budget Request

Public Affairs	
*News Media Award	\$ 1,100
Science Fair	200
Tel-Med	6,500
Dues & Subscriptions	200

Postage	3,200
Stationery, Printing	5,000
Medical Student Affairs	500

\$16,700

TV-Radio

Video Cassettes and Production Costs

\$ 5,000

\$21,700

\*Since the Public Affairs Committee voted this year to open the medical journalism competition to high school reporters and editors of hospital and clinic newspapers written for patients, it is recommended that the HMA House of Delegates approve an increase of \$300 in awards for the new categories.

PHILIP I. MCNAMEE, M.D.

TV-Radio

The purpose of the TV-Radio Committee is to institute and coordinate appropriate medical presentations in these electronic media, in order to educate the public in medical matters and in the role of physicians in maintaining the health of the community.

During the past year, the chief business of the committee was:

- 1) supervision of production of a 40-part television series, *Your Body, Your Mind*, which appeared weekly on KHET (Channel 11) and on all the cable stations. The series was sponsored by the HMA under a public health grant from the Chamber of Commerce, produced by Paul Berry Associates, filmed at Punahou School, and featured conversational interviews with physicians and health educators.
- 2) fundraising for next year's series, which included the development of a promotional film, meetings with trusts and foundations, and preparation of many grant applications.
- 3) planning for the 1979-80 season which will feature *Your Body, Your Mind* as a 26-part weekly video series, sponsored by HMSA and HMA, to follow a format similar to last year's successful program. This series will be more heavily promoted than in the past.
- 4) long-range planning for production and sponsorship of a new kind of television program for the 1980-81 season, to be filmed and broadcast by a commercial television station.
- 5) assistance and guidance to public affairs programs of a medical nature, as aired on KHET (8:30).
- 6) providing speakers for radio talk-shows and for medical public service commercials.

During the coming year, the committee will continue with its present television and radio commitments, and assist in other activities as requested.

In future programming, emphasis will be placed on the individual's role and responsibility in maintaining his or her own health, on preventative measures, and on economics of medical care.

The budget for the continuation of the TV-Radio Committee is included in the Public Affairs budget request.

JOHN CORBOY, M.D.

Tel-Med

The Tel-Med Program, a collection of tape recorded health messages available free to the public by telephone, is jointly sponsored by the HMA and HMSA. 66,233 calls have been logged this year (January 1978 through July 31, 1979). Since its inception in December, 1975, the program has received over 309,000 calls. New tapes which have been reviewed and approved during this past year, by HMA physicians, and added to the Tel-Med library include: Rape, Necessary Immunization, Chicken Pox, Menstruation, the Meaning of Fever, and Asbestos. Tapes recorded in foreign languages are also in the making. The first such tape, on Birth Control, has already been produced in Ilocano. Others currently in the process of being translated and due to be finished soon include: Medicare (Japanese and Ilocano),



Gout (Ilocano) and Atherosclerosis (Ilocano and possibly Samoan). Promotions for the program are expected to increase with Foremost Dairy devoting free advertising space on their milk cartons reminding the public to use TelMed, and more ads in the Hawaii Medical Journal reminding physicians to promote the use of Tel-Med with their patients. The programs expanded to the neighbor islands last year, and calls from these areas have increased appreciably, especially on Kauai.

#### *Recommendation:*

Inasmuch as the contract between HMA and HMSA for sponsorship of the Tel-Med program will continue through December, 1981, it is recommended that the HMA House of Delegates go on record in favor of continuing the joint effort and sponsorship of the Tel-Med program. It is also recommended that the HMA Tel-Med Executive Committee meet with HMSA on an annual basis, or more often, as necessary.

The budget for the continuation of the Tel-Med program is included in the Public Affairs budget request.

ROWLIN LICHTER, M.D.

### **Resolution No. 7**

**ACTION: Referred to the Sports Medicine Committee.**

Re: Golf Handicap for HMA Tournament.

## **REFERENCE COMMITTEE ON FINANCE AND ADMINISTRATION**

### **Emergency Medical Services (EMS)**

**ACTION: Approved.**

#### **I. Fiscal Year 1979 Status Report on the Hawaii Medical Association's EMS Program**

During the Ninth Hawaii State Legislative session of 1978, Act 148 was passed. This Act relates to the establishment and maintenance of a State Comprehensive Emergency Medical Services System. Act 148 included an appropriation for a grant-in-aid of \$687,000 to the Hawaii Medical Association for the continuation of the HMA-EMS Program in 1978-79, including a statement of required activities for HMA-EMS Program to ensure continuation of specific components of the developing EMS System in Hawaii.

Act 148 establishes a statewide emergency medical system under the jurisdiction of a single state agency, the Department of Health. It requires that the State Department of Health will make use of public and private agency resources and professional and lay experience and advice in the maintenance and continual review, evaluation, and improvement of the system. Importantly, Act 148 and Act 153 of 1978 provide for an additional source of revenue for the financial support of the 15 mandatory EMSS components and other elements essential to the comprehensive integrated delivery of emergency medical care to all persons in the State. Act 153 repeals the statutory prohibition of charging for emergency ambulance services, whereas, Act 148, in part, provides the general mechanism by which fees are to be set and charged.

In February 1979, Contract No. 9799 was signed by and between the State of Hawaii and the HMA for the HMA-EMS Program. The contract was for the period July 1, 1978-June 30, 1979 for a total of \$629,000. The provisions of the contract included the following:

1. Train ambulance personnel (EMTs and MICTs [Paramedics]);
2. Conduct continuing education of emergency physicians;
3. Provide continuing education of emergency, intensive care, and critical care nurses;
4. Provide training of public safety first responders (firefighters, police officers, and ocean lifeguards);
5. Accomplish data collection and analysis of emergency

medical care delivery;

6. Provide evaluation of emergency medical services;
7. Conduct research and develop information on technique for handling disasters and poisonings;
8. Disseminate information to the public to enable rapid and knowledgeable use of the emergency medical services system;
9. Conduct EMS National Registry exams throughout the State of Hawaii so that passage of this exam would qualify the EMTs under the provisions of Chapter 48, State of Hawaii Public Health Regulations;
10. Report on the review of triage, treatment, and transfer protocols affecting pre-hospital emergency patient care;
11. Provide to the State a comprehensive critique of categorization efforts of Honolulu hospitals; and
12. Provide to the State a general plan for dissemination of information to the public to enable rapid and knowledgeable use of EMS.

An indepth final report covering the activities of the HMA-EMS Program under this grant-in-aid will be submitted to the State Department of Health by October 1, 1979. Copies for review by interested members of the HMA will be available from both the HMA Central Office as well as from the HMA-EMS Program office. This report will include numbers trained in each of the HMA-EMS training programs, evaluation and research reports, publications to date, specifics on public information education activities, categorization results for the Oahu facilities, etc.

#### **II. Status Summary of HMA-EMS Executive Board Meetings for the Period July 1, 1978-June 30, 1979**

The HMA-EMS Executive Board met the fourth Tuesday of each month during Fiscal year 1979 and discussed major programmatic activities and provided overall policy direction to the program. The members of the Board were as follows: five voting members (three members representing the Hawaii Medical Association; one member representing the State Department of Health; and one member representing the Hawaii Hospital Association). In addition, there were several non-voting members in attendance at the meetings. The HMA-EMS Executive Board reported directly to the Hawaii Medical Association's Council. Pertinent agenda items discussed over the past fiscal year included:

- Addendum to MICT (Paramedic) Standing Orders
- MICT Pre-course Exam
- Revised MICT Grading System
- Data Substantiating Specific Needs in Ambulance Technicians' Continuing Medical Education
- Revised EMT and MICT Selection Criteria
- Revisions to Chapter 48 Ambulance Rules and Regulations
- Review of Oahu Hospitals' Categorization
- Ambulance Technician Selection Board for MICT Training
- Abstracts Accepted for ACEP 1978 Scientific Assembly, Houston, Texas, September 19-21, 1978
- Evaluations of HMA-EMS ACLS Courses
- Implementation/Evaluation of Emergency Department Physician ATLS Trauma Lab Courses
- Review on Status of HMA-EMS State Grant-In-Aid
- Lay CPR Training by Honolulu Fire Department
- I.V. Module for EMT Training
- Review of EMT-P National Registry Examination
- BCLS/ACLS Training for University of Hawaii Medical Students
- Title VII, 789 Training Grants (Review and Approval)
- Oahu Comparative Ambulance Statistics 1974-1979
- Oahu CPA Statistics
- Review of Request from Honolulu Fire Department to Train Personnel to EMT Level
- Request from Kapiolani-Children's to go on MEDICOM for Pediatric Cases
- HMA-EMS Research Projects
- Report from HMA-EMS Executive Board Task Force for Medical Control/Retraining

- Review of HMA-EMS EMT Training Programs
- MICT-Re-Entry Mechanism
- Review of Critical Care Bed Availability on Oahu
- Review of EMS Public Service Announcements for Radio and Television
- MAST MEDEVAC Followup Report
- Fiscal Year 1979 EMS Research Reports and Results
- Field Testing on New ACLS Written Final Examination

#### 111. HMA-EMS Program's Schedule of Activities to be Accomplished During Fiscal Year 1980 (July 1, 1979-June 30, 1980)

On June 22, 1979 the HMA-EMS Program submitted to the State Department of Health a recalculated EMS budget for Fiscal Year 1980. The amount requested to operate the HMA-EMS Program at its current level is \$589,326.81 for the 1980 Fiscal Year.

On June 25, 1979 a meeting was held between the State Department of Health and the Hawaii Medical Association to discuss the continuation of the HMA-EMS Program. The HMA officers agreed to accept the offer of the State Department of Health to receive \$375,000 to continue the HMA-EMS Program for the period July 1, 1979-February 29, 1980 (an eight-month period). The HMA officers also recognized the necessity to begin negotiations as soon as possible, between the HMA and the State Department of Health, to determine the future of the HMA-EMS Program following February 29, 1980.

#### *Budget request for fiscal year 1981*

MICT Graduations	\$ 600.00/year
Interim Financial	
Support for EMS	\$40,000.00
Legal Fees	\$10,000.00

LIVINGSTON M. F. WONG, M.D.

#### *Additional References:*

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Wong LMF: Emergency Medical Services (EMS), HAWAII MEDICAL JOURNAL 37:394-395, 1978.

### **HMA Auxiliary**

#### **ACTION: Filed.**

The Hawaii Medical Association Auxiliary is the counterpart to the Hawaii Medical Association. On the state level it communicates information from the component (county) Auxiliaries to the National Auxiliary and provides counties

with resource materials from National, leadership training and hopefully, the motivation to pursue projects and programs.

In an effort to promote Auxiliary unity and bridge the geographical gap between the neighbor island Auxiliaries, the State continues to budget for 2 neighbor island Auxiliary members to attend 4 meetings a year. This year funds were also provided for attendance to the Legislative Workshop conducted by Senator Patricia Saiki. Two State Newsletters this year assisted in better communications between the counties.

Auxiliary members attended 3 National Auxiliary meetings on the mainland. The fall "Confluence," a 3-day meeting in Chicago, was attended by State and County leadership and travel expenses were funded by both National and State Auxiliaries. The programs provided education in the areas of legislation, fund raising for AMA-ERF, health and leadership skills. The talent assembled at national meetings is extraordinary and enhances the commitment of members to the free practice of medicine, community health and the legislation that effects those areas. This information, in turn, is fed back to the local Auxiliaries.

The Western Regional Auxiliary meeting held in Denver in February was for the state presidents-elect and nominated presidents-elect. This provides a forum for exchange of ideas and the solving of organizational problems. The State paid for the transportation, registration and a \$25 per diem for this 2-day meeting.

Lastly, the National Convention, held in conjunction with the A.M.A. Convention in Chicago, was attended by the State President for which travel expenses and per diem were paid. Hawaii is allowed 2 delegates, in addition to the President, but the budget does not allow for expenses for the delegates. This year Convention was augmented by a full day of workshops prior to the opening of Convention.

The State Auxiliary requested an "on-site" visit by the National Auxiliary Western Regional Vice President, Isobel Dvorsky. In an effort to economize, the National Auxiliary will send National officers to local auxiliaries instead of bringing more members to Chicago for workshops, as they formerly did. Mrs. Dvorsky visited auxiliaries on Maui, Hawaii and Oahu.

Throughout the state, component auxiliaries have been responsible for legislative action by contacting legislators and monitoring committee hearings. There is continuing state wide effort to raise funds for AMA-ERF and as a result of the national effort, a check for \$3,157 was presented to the John A. Burns, School of Medicine at commencement exercises. Health education continues to be an objective of the Auxiliary as evidenced by Honolulu County's "Guest Day." A program on teenagers attracted 500 people from the community. A tape library of educational meetings both national and local is available for lending to Auxiliaries and community groups.

The Auxiliary is greatly appreciative of the support of the Medical Society and will continue to strive towards the goals of assisting the Medical Society, when requested, and to promote health and education programs.

NANCY SIMMONS  
President

### **Legal Counsel**

#### **ACTION: Filed.**

This report covers the approximate 11-month period from October 1, 1978 through September 5, 1979.

During this period your legal counsel attended the sessions of the House of Delegates and the Reference Committee; attended most of the Hawaii Medical Association Council meetings; and attended some of the Board of Governors meetings of Honolulu County Medical Society. In addition to services to Hawaii Medical Association and Honolulu County Medical Society, services were also rendered to Physicians Exchange, the EMS program, and the Tumor Registry.

Subjects on which we conferred with the officers and other authorized personnel of Hawaii Medical Association and Honolulu County Medical Society related to: a patient's



right of privacy vis-a-vis a consultant when the patient disagreed with the referring physician; the annual audit of Hawaii Medical Association; an insurance company's request for a review of the fee billing system of a non-member of Honolulu County Medical Society; the Relative Value Study and the wisdom of adoption and publication of the same; several inquiries relating to problems from the Legislative Committee; a defensive inquiry and research relating to the access of handicapped persons to the office of Hawaii Medical Association; an inquiry relating to Peer Review by specialty societies; the initial work on a review of the retention of medical records which project is not completed; research and telephone conferences relating to the dispensing of drugs and controlled substances by physicians and a review of regulations relating to radiology technology, controlled substances, and pharmacies; several inquiries, including consideration of intervention in pending litigation, relating to the right of a doctor to deny access to patient records by DSS&H personnel; attending Impaired Physician Committee planning sessions and early meetings of this committee with ongoing assistance in handling an impaired physician committee action; responding to an inquiry relating to a non-member of a neighbor island county medical society and the need for peer review; discussion with reference to a possible malpractice action under consideration by the Medical Practice Committee; research and opinion relating to the liability of physicians who are cooperating with drug enforcement activities; general administrative questions relating to the operation of 320 Ward Avenue Building; and review of an apparent fraud in billings to Hawaii Medical Service Association and fraud in advertising by two non-physicians.

Your legal counsel has no recommendations and no budget request.

V. TOMAS RICE

## Executive Director

### ACTION: Approved.

The members of this medical association can be extremely proud of their professional association and its accomplishments this past year. Federal programs, the Legislature, external relations, and good communications with specialty societies and the AMA, and especially with students, house-staff and non-members have produced a good measure of success in both recruitment of members and in getting across some understanding of what organized medicine in Hawaii is and what it can do.

The committee, commission, and bureau reports elsewhere in this annual report indicate the high level and intensity of activity by the association on behalf of its membership and the medical profession. To repeat these accomplishments is unnecessary. The only comment offered here is that there is much more to be done and physician participation is needed.

The fiscal condition of the Association is good at the present time, but forecasting for the future in terms of both accomplishments and finances always looks scary. Your association is presently considering the implementation of an automated system for its operations utilizing a minicomputer system. With eight corporations and fourteen sets of books and a combined budget of over \$3-million, the completely manual operation of the Association is being overwhelmed. The move of the Association to weaning itself off federal dollars for on-going operations continues, and the Association is beginning to fend for itself financially.

The Association is moving toward direct contacts in the field with members to provide better service for needs, and with non-members in continuous recruiting effort. Regular visits with neighbor island county societies are already underway, and plans for contact programs with Oahu physicians are being considered. The Association serves you members; please allow us to do so. Your leadership, the officers and the Council, have faced many, many issues, and have spent many, many unpaid and thankless hours in the interests of your patients and the medical profession. They deserve your interest and support.

The staff that serves you is without equal. Their talents are many and varied and is to be utilized in service to you. Membership and dues are directly related to the services that can be provided to the members and to the medical profession. These issues are always sticky issues to discuss, but appropriate support of your leadership is a most important demonstration of the desire of a profession to remain a profession. I ask for your support of your leadership.

### Recommendations:

- (1) That HMA assist the county medical societies in the membership recruitment effort.
- (2) That appropriate assistance in administrative areas be developed to offer to the county medical societies.
- (3) That this Association make every effort to adopt a balance budget each fiscal year.

JONATHAN R. WON

## Resolution No. 2

### ACTION: Not Adopted.

Re: Voting Rights of Past HMA Presidents at HMA House of Delegates

WHEREAS, the present ByLaws of the HMA allow *all* Past Presidents to vote in the House of Delegates, and

WHEREAS, this fairly large block of living Past Presidents constitutes a *significant* proportion of the total House of Delegates votes, and

WHEREAS, this large block of Past President plus the Executive Officers constitutes an unfair relationship to total delegate votes, and

WHEREAS, the usual custom in most organizations is to allow *only* the Immediate Past President a vote, so therefore be it

*Resolved*, that only the *Immediate* Past President of all Past Presidents, be allowed a vote in the House of Delegates, on the basis of being a Past President, and be it further

*Resolved*, that Past Presidents can continue to vote only if they are elected Delegates, alternate, Councillors, etc.

PATRICK J. WALSH, M.D.

## Resolution No. 5

### ACTION: Not Adopted.

Re: Actions by the Council

WHEREAS, as defined in the Charter of Incorporation of HMA, "the corporate powers, business, and property of the corporation shall be exercised, conducted, and controlled by a House of Delegates . . ." and,

WHEREAS, at times the actions of the Council has not reflected the intent of the House of Delegates, now, therefore, be it

*Resolved*, that any action of the Council which does not reflect the will of any previous House be null and void unless approved by the House prior to initiation of the actions voted by the Council.

MARION L. HANLON, M.D.

## Resolution No. 6

### ACTION: Not Adopted.

Re: Election of Delegates to AMA

WHEREAS, all officers and selected representatives of HMA, except the AMA Delegates and Alternate Delegates, are limited by the official By-Laws as to their stay in office, and

WHEREAS, this assures the involvement of a greater proportion of the membership in the affairs of HMA, and

WHEREAS, the affairs of the American Medical Association should be of vital concern to all members of HMA, so therefore be it

*Resolved*, that the term of the office of the HMA delegate(s) and alternate delegate(s) to the AMA be limited to

three consecutive terms, and be it further

*Resolved*, that the By-Laws Committee of HMA be instructed to make the required changes in the HMA By-Laws to reflect this action, and be it further

*Resolved*, that this limit of term of office become effective at the next election following the ratification of the By-Laws change by the House of Delegates.

MARION L. HANLON, M.D.

## President

### **ACTION: Approved as amended.**

The past year has been a challenging, varied and critical year of my life. As you all know, I was sworn into office in absentia following a mild heart attack. Following a period of recuperation, I underwent a coronary by-pass surgery from which I recovered to actively assume the duties of the office of president. During my period of disability the Association was efficiently run by the officers, committees and particularly our efficient and loyal staff. I am grateful for the willing acceptance of responsibilities by all concerned. Through their devotion to their assigned tasks, the diverse activities of the Association has been accomplished efficiently and with a minimum of disruptions. My special thanks goes to our President-elect, Dr. Douglas Bell, II, who filled in for me during my period of incapacitation.

The major issues presented by the House of Delegates have been met by the Council and the Committees. The past year's activities are contained in the reports of the Committees and Commissions. I will touch on some of the areas where the reports may not cover adequately.

Today the practice of medicine entails not only serving your patients with the best in medical care, but also the need to join your fellow physicians within the federation of organized medicine. The cooperation of all physicians is needed in our dealings with government cost of medical care, and other vital issues affecting the practice of medicine.

Over the past few years we have seen an escalating number of bills and resolutions introduced in each session of the State Legislature. We are fortunate in having a very active, dedicated, and efficient staff that reviews all bills and resolutions introduced and brings to the attention of the Legislative Committee and the officers all pertinent measures for action. We would like to point out that there is an urgent need for physicians to become involved in the legislative process. If we do not get involved, the enacted bills may not be to our liking. In some instances we need massive involvement of all physicians—whether they are members or non-members of the HMA. An example is our drive to obtain realistic payment for the medical care of Medicaid patients. As many of you are aware, we are being reimbursed on the basis of our 1975 profiles which are grossly inadequate and in many instances below the cost of providing this care. If we remain silent and do not show a massive show of concern, the legislators will conclude that we are satisfied with the status quo and nothing will happen during the next session of the legislature.

Following a continuing effort of twelve years, the legal capacity of minors to consent to examination and treatment for pregnancy, venereal disease, the family planning became law on June 26, 1979. This law allows discretion to the physician as to whether the parents or guardians of the minor are to be informed of the medical services. In this law, medical services are defined as "the diagnosis, examination, and administration of medication in the treatment of venereal disease, pregnancy, and family planning services. It shall not include surgery." For the purpose of this act a minor is a person between the ages of 14 through 17 years.

On one of the most dramatic events of the past session of the state legislature was the response of the ophthalmologists to the attempt of the optometrists to amend the Optometry Practice Act to permit the use of diagnostic drugs. The reaction of the ophthalmologists against this incursion of the optometrists into the practice of medicine was very impressive. Their lobbying activity was extensive—they presented testimony to nearly all the legislators, the governor, the news

media, the director of the department of regulatory agencies and the attorney general. When one of the representatives, who introduced a bill to carry out the purpose of the optometrists, refused to see the ophthalmologists to hear the other side of the issue, a large number of ophthalmologists went to the representative's district and obtained over 300 signatures of his constituents opposing the optometrists using diagnostic drugs. Following this massive show of opposition to the bill, the legislature tabled this measure during the past session. But we are certain it will be resurrected next year, and we must be prepared for the onslaught.

The cost containment issue is heating up in Hawaii as well as across the country. It is the position of the HMA that we follow the lead of the AMA in approaching the issue of rising health care costs from a voluntary standpoint, without government intervention through legislation, rules and regulations. This includes the present national administration which is pushing very hard to institute mandatory hospital cost controls.

The Cancer Center of Hawaii has been a continuing subject on the agenda of the HMA Council for the past 3 years. Late last year, the HMA withdrew support of and participation in the Cancer Center because previous agreements reached with the University have not been carried out by the University. In fact, the original concept of the Cancer Research Center was supported by the HMA, and many other agencies, because the concept of the Center's development was that the community would be a major mover of the project. As it turned out, because of rigid University regulations, the University felt that it could not turn over such a project of the University to anyone, and must remain the final authority. While we have encouraged those physicians with an interest in cancer to become involved as individual physicians, the HMA remains firm in its present position until an acceptable atmosphere is obtained.

The students at the John A. Burns School of Medicine are showing an interest in organized medicine. We should assist them in their organizational effort by providing them secretarial and administrative help so that they would become willing student members of the Association.

### *Recommendations:*

- (1) Provide secretarial and administrative assistance to the medical students at the John A. Burns School of Medicine in their organizational effort to join organized medicine.
- (2) Encourage greater participation of physicians in our dealings with the State Health Planning and Development Agency and other governmental agencies that affect the practice of medicine.
- (3) Urge the involvement of all physicians in the direct support of candidates for political office by generously contributing to fund raising efforts and by participating in the grass roots activities of the elective process.

GEORGE GOTO, M.D.

## Treasurer and Finance

### **ACTION: Approved as amended with the following recommendations:**

- (1) That the registration fees for the HMA Annual Meeting be left to the discretion of the Council depending upon the AMA's involvement.
- (2) That three months prior to the next annual meeting of the HMA, a balanced budget be established based on programs that fit into clearly established missions and goals of the HMA.

As your Treasurer is also the Chairman of the Finance Committee, this will be a combined report. As cost of goods and service rise, there is the ever-increasing chance of true deficits for the HMA. Sound planning and attention to the financial affairs of the HMA must be an integral component of your Association. Last year, as much your Treasurer attempted to look at the financial operations of your HMA without as much dependence on federal funds. The federal monies through the operation of the Hawaii Tumor Registry



continue but the only funds for the EMS program came through the State and therefore, was only for direct costs of the program. PSRO shared arrangements with HMA for space and services have been gradually separated, and HMA is being weaned off the federal dollar as a part of its operation, although the PSRO dollar is an "in and out" situation. Your Treasurer and Finance Committee have conscientiously and diligently looked after the financial affairs of the Association on your behalf. It is our estimate that the relatively large deficit budget adopted by the HMA House of Delegates for 1979 will not materialize and that a modest addition will be made to the members' equity at the end of 1979.

For 1980, your Treasurer and Finance Committee have looked into each income and expense item with hard scrutiny and have proposed the attached budget. In presenting this proposed budget, your Finance Committee wishes to present the following recommendations for adoption:

Recommendations:

- (1) That the dues for 1980 be \$270.
- (2) That, because much of our activities depend on dues dollars, that the HMA embark on an aggressive program for recruitment of new members as well as those members which have dropped from membership.
- (3) That the charge of \$100 for CME approval for specialty societies and voluntary agencies, and the policy of a minimum charge of \$250, plus travel costs for hospital surveys, remain.
- (4) That a contract for services provided in 1980 to the Honolulu County Medical Society be adopted for an annual payment of \$86,100, subject to negotiation and approval by the HMA Council.
- (5) That this budget be adopted as presented.

WILLIAM H. HINDLE, M.D.

Building

ACTION: Approved as amended.

The utilization of the 320 Ward Avenue building by both its tenants and the HMA and its affiliated physician organizations both during the day and night remain at an ever high level. Physicians' Committees met over 544 times during the past year. HMA space usage increased by an additional 1,026

square feet with the consolidation of Pacific PSRO operations in September. The total space occupied by HMA and its related organizations is 8,600 square feet or approximately 40% of the building.

Occupancy remains high at 320 Ward Avenue. It is projected that there will be less than a 3% vacancy factor for the total of the year of 1979.

High occupancy, as well as an active HMA membership, has placed large demands on the building's parking facilities. The parking availability for HMA members remained a problem through August. We believe that this problem has been corrected by the retention of a parking lot manager. While some administrative details and procedures remain to be finalized, the initial effects on the availability of parking to our members have been dramatic. Physicians are finding parking spaces readily available when they visit their building to attend meetings.

The Building Committee has actively been involved in the management of the building, including decisions regarding lease negotiations, recommendations for major maintenance projects, review and revision of leasing policies in light of our inflationary economic climate (e.g. shorter leases, step-up rate increases, separation of parking space and space negotiations) and also the development of a building budget to coincide with the HMA operation's budget.

The 1980 Building Budget follows this report. Because of internal accounting conventions, the monies received from Federal projects housed at 320 Ward Avenue for occupancy costs are not included in the revenue section of the budget and, then the earning power of the building as an asset is understated. It is projected for 1980 that Federal revenues for occupancy cost will be approximately \$38,100.

Inflation in the form of rising costs, especially those costs associated with petroleum base products appears to be our greatest short term problem. However, in spite of the inflationary forces the building continues to perform well. In 1979, fiscal projections indicate that the building will generate a surplus cash from its operations of \$9,600. This surplus will be applied in 1979 agreement of sale payment. The remaining amount will be funded by the capital advance fund.

Last year, 1978, payment on our agreement of sale was met by \$8,500 from the building operations, \$48,000 from the capital advanced fund and \$43,500 from HMA operations.

1980 Budget  
Hawaii Medical Association

INCOME:	Estimated 1979	Budget 1979	1980 Budget
Dues .....	\$175,000	\$183,800	\$206,900
Journal .....	50,000	60,000	52,000
Annual Meeting .....	20,000	22,000	18,000
Roster .....	1,000	2,000	1,500
Indirect Costs—EMS (C&C) .....	- 0 -	- 0 -	- 0 -
Indirect Costs—HTR .....	43,000	- 0 -	- 0 -
Indirect Costs—EMS (State) .....	- 0 -	- 0 -	- 0 -
Interest Earned .....	18,000	13,000	16,000
Miscellaneous .....	100	100	100
Dues Collection Service .....	1,700	1,500	1,700
PSRO Salary Reimbursement .....	200,000	223,000	201,650
PSRO Services .....	43,800	43,800	44,000
PSRO Meeting Expense .....	7,000	7,000	7,000
Fee Survey .....	450	- 0 -	- 0 -
CME .....	1,500	1,500	1,000
Printing/Xeroxing .....	4,500	4,500	4,500
Contract Services—HCMS .....	82,400	82,400	86,100
Other Reimb. Revenues .....	5,500	10,500	4,500
Retirement Reimbursement .....	120,000	123,365	131,000
Payroll Tax Reimbursement .....	45,000	- 0 -	47,000
EMS Accounting Reimbursement .....	5,000	5,000	1,250
	<u>\$823,950</u>	<u>\$783,465</u>	<u>\$824,200</u>

While there is some question regarding the treatment of equity payments in determining HMA occupancy costs, no matter how it is calculated, including or excluding equity payments, the HMA's occupancy costs compare extremely favorably to the current market rental values. For example, if the capital fund contributions (equity payment + interest) are considered part of the occupancy cost, then HMA paid a rental rate of .56/sq. ft./month. If capital fund payments are excluded then HMA paid .03/sq. ft./month. The above rates include federal monies received.

Recommendations:

- (1) That the Building Budget be approved as submitted.

GEORGE GOTO, M.D.

Secretary

ACTION: Filed. The minutes of the Council meetings were ratified as circulated.

The total membership of the Association as of December

31, 1978 was 903, a decrease of 25 compared to December 31, 1977 which was 928. The special members numbered 32, an increase of one from the previous year. As dues waiver (retirement, life members, and financial hardship) was granted to 150 members, an increase of 13 over the previous year.

Six members died since the last meeting: Drs. Douglas Bell Sr., Richard Lam, Felix Lafferty, Donald Dietrich, Isami Mirikitani, and R. Mashruwala.

By counties, the active membership was made up as follows as of December 31, 1978:

County	Active Dues		Special	Total
	Paying	Waived		
Honolulu	603	123	30	756
Hawaii	47	12	2	61
Maui	59	9		68
Kauai	12	6		18
	721	150	32	903

1980 Budget  
Hawaii Medical Association

EXPENSES:	Estimated 1979	Budget 1979	1980 Budget
Salaries .....	\$400,000	\$418,900	\$417,650
Auditing .....	6,600	5,000	6,800
Auto Expense .....	8,500	8,000	8,800
Computer Reports and Supplies .....	700	500	1,000
Council Expenses .....	4,500	4,500	4,500
Donation .....	1,000	1,000	1,000
Dues and Subscriptions .....	800	800	500
HAMPAC Education .....	1,000	1,000	500
Insurance and Bond .....	8,000	5,000	10,000
Lease—Office Equipment .....	3,600	3,600	3,600
Library Contribution .....	5,000	5,000	5,000
Legal and Professional .....	12,000	19,000	20,000
Meeting Expense .....	20,000	15,000	18,000
Postage .....	4,800	4,000	4,800
President's Assistant .....	- 0 -	12,000	- 0 -
President Contingency Fund .....	1,000	1,000	2,000
Repairs and Maintenance .....	5,000	2,500	5,000
Retirement Contribution .....	105,000	105,000	117,000
Stationery, Printing Supplies .....	15,000	8,000	8,000
Taxes .....	63,000	16,000	63,000
Telephone .....	3,000	5,000	4,000
Travel .....	12,000	12,000	10,000
Auxiliary .....	12,000	12,000	16,600
Committee Expenses .....	25,000	39,100	34,200
Journal .....	40,000	45,000	43,000
Annual Meeting .....	20,000	22,000	18,000
Roster .....	3,600	3,750	3,700
CME .....	8,100	12,800	9,800
Fee Survey .....	- 0 -	- 0 -	- 0 -
Council Contingency .....	2,500	12,000	5,000
Education and Training .....	1,800	2,000	1,000
Interest-Equipment Loan .....	2,000	2,000	2,400
Miscellaneous .....	100	1,000	500
Spec. Authorized Exp.-HTR .....	10,000	10,000	10,000
*Special Council Contingency .....	- 0 -	40,000	40,00
Equipment Purchase .....	2,000	3,000	1,000
Survey-Computer .....	8,200	- 0 -	- 0 -
Trustee Campaign .....	- 0 -	- 0 -	2,000
Computer Lease/Maintenance .....	- 0 -	- 0 -	19,200
MICT Graduations .....	- 0 -	- 0 -	600
TOTAL EXPENSES .....	\$812,800	\$857,450	\$918,150
NET GAIN (LOSS) .....	\$ 11,150	(\$ 73,985)	(\$93,950)

\*This item is designed for support of the HMA-EMS Program and is to be utilized, if deemed necessary and released by the HMA Council, to carry the Program while waiting other funding. It is anticipated that any expenditures from this budget time will be fully reimbursed to HMA when other funding is available.



As of July 31, 1979, the membership has decreased to a total of 895, with 696 Active Dues Paying, 167 Active Dues Waived, and 32 Special Members.

One encouraging fact, however, is that membership in 1978 dropped from a high of 928 in January, to 895 in August 1978, then rose to 903 in December. We usually do not lose most of our dropouts earlier in the year and then pick up new members later in the year. So there is a reasonable hope that our decline in membership has finally bottomed out. A more active membership drive is now under way and a pilot program offering rebates of \$100 on next year's dues to members enrolling a new member in HMA has been approved by HMA and AMA.

Since the last meeting, the Council met on the following dates: November 3, 1978, December 8, 1978, and February 2, March 2, April 6, May 4, June 1, July 6, and September 7, 1979. Copies of the minutes of these minutes are attached for ratification of the House.

NEAL E. WINN, M.D.

Hawaii Foundation for Medical Care

ACTION: Approved.

The Foundation has remained inactive during 1979. There has been some discussion that the Foundation would be the vehicle through which any attempt at planning, development, or implementation of HMA concepts or programs would be accomplished. The Bureau of Research and Planning has discussed such possibilities as has the Board of Governors of the Honolulu County Medical Society. The Council has discussed such programs in light of the Foundation being a possible mechanism to accomplish such activities if desired. At this time, no determination has been made to begin such programs although the Council has continued to investigate such concepts and possibilities.

Recommendations:

- (1) Because of the possibility of future activity, the Hawaii Foundation for Medical Care should be continued as a subsidiary of the HMA for next year,
- (2) That the HMA Council continue to investigate possible activities and functions of the Foundation and report to this House next year.

WINFRED Y. LEE, M.D.

Community Research Bureau

ACTION: Approved.

This Bureau remains an important fiscal agent for the Association in handling funds to charitable, educational, literary, or scientific purposes. During 1979, this Bureau continued to handle funds for our Emergency Medical Services Program and funds awarded by the Public Health Committee of the Chamber of Commerce to assist in production and presentation of public health education programs on television. Current financial statements for the Bureau and these programs handled are available in the HMA Office. Activities and operations of these two programs are reported elsewhere in these proceedings.

Your Community Research Bureau has no recommendations to offer other than that it continue with its present functions.

O. D. PINKERTON, M.D.

Resolution No. 9  
(submitted at 4:00 p.m., October 8, 1979)

ACTION: There was no action taken by the House of Delegates on this late resolution as it was not considered an item of an emergency nature.

Re: Current Election/Nomination Process

1980 Budget  
Hawaii Medical Association  
Schedule of Committee Expenses

	Estimated 1979	1979 Budget	1980 Budget
<b>Legislative</b>			
Legal Counsel .....	8,500	8,500	12,000
Dinner Entertainment .....	- 0 -	- 0 -	- 0 -
Today's Health .....	- 0 -	300	- 0 -
Miscellaneous .....	- 0 -	400	- 0 -
Printing .....	- 0 -	1,500	- 0 -
	8,500	10,700	12,000
<b>Public Affairs</b>			
News Media Award .....	800	800	1,100
Science Fair .....	200	200	200
Tel-Med .....	6,500	6,500	6,500
Salaries .....	- 0 -	- 0 -	- 0 -(HMA Budget)
Office Space .....	- 0 -	- 0 -	- 0 -(HMA Budget)
Meeting Expenses .....	- 0 -	- 0 -	- 0 -(HMA Budget)
Insurance, Legal Services .....	- 0 -	- 0 -	- 0 -(HMA Budget)
Office Equipment .....	- 0 -	- 0 -	- 0 -(HMA Budget)
Dues and Subscriptions .....	- 0 -	200	200
Postage .....	- 0 -	3,200	3,200
Stationery, Printing .....	- 0 -	5,000	5,000
Travel .....	- 0 -	- 0 -	- 0 -(HMA Budget)
Miscellaneous .....	- 0 -	- 0 -	- 0 -
Medical Student Affairs .....	- 0 -	500	500
	7,500	16,400	16,700
<b>TV-Radio</b>			
Video Cassettes and Production Costs .....	3,000	3,000	5,000
<b>Sports Medicine</b>			
Seminar .....	500	500	500
TOTAL COMMITTEE EXPENSES .....	\$19,500	\$39,100	\$34,200

Hampac

ACTION: Approved.

HAMPAC support activities in 1979, a non-election year, were primarily directed toward physician education and providing fund raising support for legislators supportive of the purposes of organized medicine. HAMPAC provided support to 16 legislators. Total HAMPAC membership of 195 was a drop from the 205 of 1978 and the 310 of 1977.

Notwithstanding this drop in membership during 1979, the HMA delegation was again recognized at the AMA Annual Meeting in July and presented with the AMPAC Leader-

ship Award. This award is presented to those states whose President, President-elect, Delegates and State Pac Chairman are all sustaining members of AMPAC/HAMPAC.

During September, Becky Kendro and Attorney Tom Rice attended AMPAC's Third Annual Federal Election Law Conference as HAMPAC's official representatives. The conference dealt primarily with HAMPAC administrative responsibilities under federal law and regulation.

In looking forward to the upcoming 1980 election year, your HAMPAC committee will concentrate on an aggressive membership drive in its efforts to generate and sustain interest in the political process within our physician families.

1980 Budget  
Hawaii Medical Association—Building Fund

	Current Yr. 1979 6 - Months	1979 Estimated	1979 Budget	1980 Budget
<b>Income:</b>				
Rent—Lease .....	80,074	160,148	161,110	145,893
Rent—Parking .....	308	616	600	13,116
Other—Interest, Etc. ....	510	1,020	500	1,000
TOTAL INCOME .....	80,892	161,784	162,210	160,009
<b>Expenses:</b>				
<i>Owner's Expenses:</i>				
Building Repair & Maintenance .....	- 0 -	2,023	11,000	5,000
Insurance .....	- 0 -	360	360	360
Electricity .....	1,200	2,400	2,400	1,844
Commission—Leasing .....	1,219	2,438	1,102	2,438
Professional & Legal .....	- 0 -	600	500	600
Lease Rent .....	19,740	39,480	39,480	39,480
Interest .....	34,052	68,104	68,074	64,943
Depreciation .....	16,447	32,894	30,900	32,896
Miscellaneous .....	95	190	120	120
TOTAL OWNER'S EXPENSES .....	72,753	148,489	153,936	147,681
<b>Common Area Expenses:</b>				
Salaries .....	2,121	- 0 -	4,560	- 0 -
Bldg. Repair & Maintenance .....	7,288	14,576	7,200	8,316
Landscape Maintenance .....	3,382	6,764	7,640	8,400
Janitorial .....	5,432	10,864	10,980	12,072
Contract Repairs .....	427	854	2,850	1,596
Maintenance Supplies .....	1,184	2,368	3,600	4,200
Air Conditioning .....	3,598	7,196	7,980	9,504
Parking .....				13,800
Refuse .....	406	812	780	888
Pest Control .....	165	330	252	372
Electricity .....	12,261	24,522	30,624	29,327
Water .....	2,177	4,354	3,180	3,900
Management Fees .....	4,992	9,984	9,984	12,480
Insurance .....	841	1,682	3,252	3,360
General Excise Tax .....	2,096	7,200	7,217	7,267
Miscellaneous .....	37	74	360	- 0 -
TOTAL COMMON AREA EXPENSES .....	46,407	91,580	100,459	112,986
<b>Recoverable Expenses:</b>				
Real Property Tax .....	5,987	11,974	12,396	12,500
Assessment .....	4,090	4,090	4,600	4,000
TOTAL RECOVERABLE EXPENSES .....	10,077	16,064	16,996	16,500
<b>Direct Recoveries</b>				
CAM Recoveries .....	7,895	7,800	7,500	7,800
Real Property Tax .....	6,783	13,566	8,406	6,800
Assessment .....	774	1,548	2,800	2,800
TOTAL DIRECT RECOVERIES .....	15,452	22,914	18,706	17,400
TOTAL EXPENSES—NET .....	113,785	233,219	252,685	262,263
NET INCOME—INCREASE (DECREASE) .....	(32,893)	(71,435)	(90,475)	(102,254)



In order to carry out the proposed activities for the coming year we request a budget of \$500 for the 1980 HAMPAC educational fund.

L. Q. PANG, M.D.

Nominating

ACTION: Approved.

The nominating Committee met twice to receive nominations for officers and other elected positions of the Hawaii Medical Association that are to be elected by the HMA House of Delegates at its Annual Meeting October 8-12, 1979. The Nominating Committee submits to the House of Delegates the following slate of nominees:

- President-Elect ..... Neal E. Winn, M.D. (1980)
- Secretary ..... Kwong Yen Lum, M.D. (1980)
- Treasurer ..... William H. Hindle, M.D. (1981)
- AMA Delegate ..... Herbert Y. H. Chinn, M.D. (1981)
- Councillor from Hawaii..... Arch T. Wigle, M.D. (1981)
- Councillor from Maui ..... Denis Fu, M.D. (1981)
- \*Councillors from
  - Honolulu ..... Albert C. K. Chun-Hoon, M.D. (1981)
  - Alan B. Hawk, M.D. (1981)
  - James Lumeng, M.D. (1981)
  - Andrew L. Morgan, M.D. (1981)
  - Young K. Paik, M.D. (1981)
  - Myron E. Shirasu, M.D. (1981)
  - Paul Y. Tamura, M.D. (1981)

ANDREW MORGAN, M.D.

Election

ACTION: The report of the Nominating Committee was presented, and the President called for nominations from the floor. There were no further nominations. Drs. Ann Catts and William Iaconetti were appointed tellers, and the ballots were distributed. The following were elected:

- President-Elect ..... Neal E. Winn, M.D. (1980)
- Secretary ..... Kwong Yen Lum, M.D. (1980)
- Treasurer ..... William H. Hindle, M.D. (1981)
- AMA Delegate ..... Herbert Y. H. Chinn, M.D. (1981)
- Councillor from Hawaii ..... Arch T. Wigle, M.D. (1981)
- Councillor from Maui ..... Denis Fu, M.D. (1981)
- Councillors from
  - Honolulu ..... Albert C. K. Chun-Hoon, M.D. (1981)
  - James Lumeng, M.D. (1981)
  - Andrew Morgan, M.D. (1981)
  - Myron Shirasu, M.D. (1981)

The Nominating Committee was elected as follows:  
Honolulu—Drs. Ann Catts, William Dang, George Goto,  
Andrew Morgan, E. Lee Simmons; Hawaii—Arch Wigle;  
Maui—Denis Fu; Kauai—Yonemichi Miyashiro.

New Business

ACTION: The House of Delegates voted to commend Dr. Goto and give him a standing ovation for his outstanding leadership as HMA President this past year.

The meeting adjourned at 5:30 p.m.

NEAL E. WINN, M.D.

Secretary

Awards

Medical Reporting Awards

- Tom McWilliams—KHON-TV 2
- Kathy Titchen—Star-Bulletin
- Aura Wilson—Castle High School
- Dick Habein (Special Certificate of Recognition)—Star-Bulletin Health Page

A. H. Robins Award—(1979 Physician Award for Community Service) to Calvin C. J. Sia, M.D.

Sportsmen's Awards

Tennis:

- Singles champion—Gerard Dericks
- Doubles champions—Benjamin Chang and Gerard Dericks

Golf:

- President's Trophy—Paul Tamura
- Robert Miyamoto Perpetual Trophy—William Yarbrough
- John Felix Perpetual Trophy—Paul Tamura
- George Mills Perpetual Trophy for Pharmaceutical Representatives—James Asato

**as•so•ci•a•tion** (e•sō sē•ā'shen, -shē-) *n.*

**1.** The act of associating. **2.** The state of being associated; fellowship; companionship. **3.** A body of persons associated for some common purpose; society; league. Abbr. *ass.*, *assn.*, *assoc.*

# JOIN US

## We Can Do So Much More Together



**HAWAII MEDICAL ASSOCIATION**

320 WARD AVENUE, HONOLULU, HAWAII 96814









# Diphyllobothrium latum Infection in a Hawaiian Male

PETER W. L. HO, M.D., FRANCIS D. PIEN, M.D., and  
REUBEN C. GUERRERO, M.D., *Honolulu*

Among the intestinal parasites, *Diphyllobothrium latum* is relatively rare in the United States, only 25 isolates being reported in 1976 by state health departments (excluding Alaska). The largest number of isolates were from the Middle Atlantic states. We found *D. latum* infection in a Hawaiian man.

## Report of a Case

A 45-year-old man from Hawaii went on a 5-day fishing trip to Alaska. Because of his taste for sashimi, he ate raw, fresh water fish twice. Two weeks later, the patient began to have abdominal discomfort and frequent, watery, non-bloody diarrhea. He complained of weakness, but denied fever, vomiting, parasthesias or dizziness. Physical examination was unremarkable except for slight abdominal tenderness and hyperactive bowel sounds. A stool specimen extracted by the formalin-ether method revealed 10 *D. latum* ova per high power microscopic field. Laboratory results were otherwise normal, except for 13% eosinophils in the differential white count. The patient was treated with a single 2 gram oral dose of Yomesan (niclosamide). He reported prompt cessation of the abdominal discomfort and diarrhea within 24 hours. No worm segments were seen in his stool. Repeat stool specimens for *D. latum* ova at 2 weeks and 3 months after therapy were negative.

## Discussion

*D. latum* infections have been reported mainly in cooler parts of the northern hemisphere; most

notably in the Scandinavian and Baltic countries, the lake region of France, Switzerland, Northern Italy, Japan and the Great Lakes of North America.<sup>2,3</sup> One quarter of the population in East Finland are infected with the worm.<sup>3</sup> Older studies among Eskimos reported an 80% incidence of *D. latum* in stool specimens in Port Harrison, Canada,<sup>4</sup> and a 15% incidence in the Bethel area of Alaska.<sup>5</sup> Recent dietary changes due to patient education have caused a dramatic decline in the incidence of *D. latum* infections in Bethel, Alaska. (Dr. Frank P. Pauls, personal communication.)

Diphyllobothriasis is caused by the presence of a fish tapeworm in the human small intestine. Operculated eggs are discharged in feces and hatch in freshwater to ciliated larvae. The larvae die in a few hours unless ingested by a small crustacean copepod. When the infected copepod is then ingested by fresh-water fish, the larvae develop into 4-6 mm. sparganum larvae in fish muscle fibers. These larvae can be killed by temperatures exceeding 56°C for five minutes or more.<sup>3</sup> Man is infected by eating raw, pickled or improperly cooked freshwater fish. (Usually trout, northern pike, carp or whitefish in the United States.) It takes 3 weeks for an adult worm to mature to discharge eggs and proglottids. The adult worm grows up to 10 meters in length and may release as much as a million eggs per day.<sup>6</sup>

Most persons who harbor *D. latum* are asymptomatic.<sup>2</sup> Clinical manifestations include neurologic and gastrointestinal symptoms: mental changes, abdominal pain, diarrhea, stomatitis and glossitis.<sup>2,7</sup> The best known feature of fish tapeworm infection is megaloblastic anemia, clinically similar to pernicious anemia.<sup>3</sup> The reason why only less than 2% of carriers

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Accepted for publication June, 1979.

develop megaloblastic anemia is an unsettled question.<sup>3,6</sup> Neurologic signs of vitamin-B<sub>12</sub> deficiency are more common; about 30% of the carriers have parasthesias and impaired vibratory sensation.<sup>8</sup>

The recommended treatment for diphyllorhynchiasis is a single oral dose of 2 gram of Yomesan.<sup>9</sup> This drug is safe and effective, but because of limited demand in this country, the drug is unlicensed and available only from the Parasitic Drug Service, Center for Disease Control, Atlanta, Georgia.

Because many people in Hawaii and elsewhere enjoy eating raw fish, they must be cautioned about the possibility of acquiring parasitic disease in areas where the fish

tapeworm is endemic. A detailed dietary history must be obtained in any person who develops gastrointestinal symptoms, especially after recent travel.

### Summary

Diphyllobothriasis is relatively rare in this country. A 45-year-old Hawaiian developed *D. latum* infection from eating raw fish in Alaska. Vague abdominal discomfort and diarrhea caused him to seek medical care. Treatment with Yomesan caused prompt cessation of symptoms and cure of infection. A brief description of the life cycle and clinical symptomatology of the fish tapeworm is included.

### REFERENCES

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5. Hitchcock D: Parasitological study on the Eskimos in the Bethel area of Alaska. *J Parasitol* 36:232-234, 1950.
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9. Perera DR, Western KA, Schultz MG: Niclosamide treatment of cestodiasis. Clinical trials in the United States. *Am J Trop Med Hyg* 19:610-612, 1970.

### MEDICAL MANAGEMENT PROGRAM

- ♦ Billing procedures that produce results
  - ♦ Insurance processing and follow-up procedures
  - ♦ Computer software analysis
    - ♦ Personnel efficiency analysis, training, policies, etc.
    - ♦ Inter-office communications
    - ♦ File systems and chart control

Verne Miller, MGMA, ARMA  
Professional Management Services

Amfac Center  
523-2923





## First, Settle Your Debts

The State of Hawaii has an unexpected surplus, and Budget Director Anderson is submitting options to the legislature for reimbursing the taxpayers.

But wait! Before any surplus can be declared, let's examine the debit side of the ledger, to be sure there are no obligations outstanding.

Last year under an amendment to the Medicaid Law, the legislature decided not to reimburse physicians at the 75th percentile of the 1978 DSSH profiles, but to set payments at the 1975 level. Now, it's one thing to ask physicians to support the program by caring for patients at a 25% discount off last year's fees; most don't mind this charitable contribution. But for legislators to proffer payments at 75% of the 1975 scale is extortion! Inflation reduces this compensation to as little as 35% of current fees.

Many physicians, unable to afford increasing their subsidy, simply stopped seeing Medicaid patients. The rest of us continue underwriting the program, receiving about 35 cents on the dollar. This means that of three Medicaid patients, we are paid for one and see the other two "for free," while the state declares a surplus!

So before counting its cash, the state must settle the old debts. First, the fee schedule must be brought back up to the 75th percentile of current annual profiles. The state has protested that this would cost an extra \$20 million, which reveals the amount Hawaii's physicians donated to the program last year; an average of more than \$10,000 a piece (over and above the 25% discount), which is mighty generous! Fortunately, the \$67 million surplus will cover this, and perhaps allow rebates for prior years.

Next, realistic Medicaid funding must be established and maintained. The old legislative philosophy of budgeting medical payments with whatever's left in the bottom of the welfare bucket won't work any more.

Medicaid funding remains a federal-state responsibility. The legislature has defaulted by forcing physicians (but not landlords or grocers) to support the scheme through increasing donations of time and money. The apparent surplus represents a \$20 million loan by Hawaii's physicians last year, which must first be repaid before any discussion of taxpayer refunds.

New militance grows among physicians; a union is forming. We predict that if the legislature does not promptly heed its responsibility, physician participation will drop below the required 51%, and federal Medicaid funding will automatically cease. And when *that* happens, the state will need every penny of the "surplus." Staple this to your letterhead and mail it to your legislator, with a copy to the governor. Let them know you won't take it anymore.

JMC

## Signs Of The Times

The *Canadian Doctor Newsletter* reports that the expected lifetime earnings of a plumber with a 10th grade education now exceed those projected for Canadian physicians. (Care to guess which group has the labor union?)

Clergymen in California are now purchasing ministry malpractice insurance, to protect them from liability claims arising as a result of counseling and pastoral guidance.

JMC

## Your Body, Your Mind

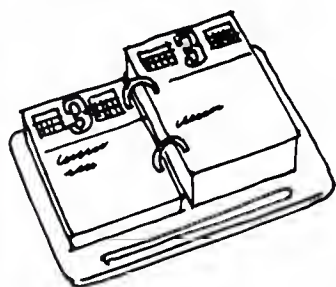
This year our television information series grows better than ever, in a convenient new time (Sunday evenings at 6:00 on KHET, channel 11). The programs feature HMA physicians in lively, sometimes controversial conversations on various medical topics. The series, jointly sponsored by the HMA and Tel-Med, was made possible by a grant from HMSA. Display your poster and Tel-Med brochures, and remind your staff and patients; it's *your* public image, doc.

JMC

## Beats Black Lung

In all the fuss over radiation exposure at Three Mile Island, it's worth knowing that the average individual dose, cumulative over the 10-day period to people within 50 miles, was 1-2 millirem. You get this dose from a chest x-ray, or a year's worth of TV. Cancer does not arise below 100,000 millirem, and genetic effects from radiation (even in Japan) have never been demonstrated in humans.

JMC



## Continuing Medical Education

### CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

#### LOCAL ACCREDITED PROGRAMS

##### ONGOING

##### American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Third Tues. w/Maui Mem. Hsp.

##### John A. Burns School of Medicine

1. Dept of Medicine
  - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
  - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
  - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
  - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
  - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
  - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
  - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
  - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
  - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
  - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
  - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
  - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.

5. Dept. of Pediatrics
  - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
  - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
  - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
  - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
  - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room 11).
7. Dept. of Surgery
  - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
  - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
  - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
  - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
  - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
  - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
  - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

##### Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respcio, B.S.N. at (808) 537-5966.

##### Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

##### Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Fourth Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m. (Preventive Med.-Public Hlth. oriented.)



### Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

### Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.  
First—Didactic Presentation  
Second—Perinatal-Neonatal Topics  
Third—Obstetrics Topics  
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

### Kuakini Medical Center

1. G.I. Conference, Third Tuesday, 8-9:00 a.m.
2. Nephrology Conf., Fourth Wednesday, 8-9:00 a.m.
3. Oncology Conf., every Thursday, 7:30-8:30 a.m.
4. Pulmonary Conf., Third Thursday, 1-2:00 p.m.
5. Surgical Conf., First, Second, Third Fridays, 12:45-1:45 p.m.
6. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
7. Ophthalmology Departmental Mtg., Second Tuesday, 1-2:00 p.m.
8. Visiting Professor Lectures.

9. Medical Mortality & Morbidity Conf., Fourth Tuesday, 1-2:00 p.m.
10. Endocrine & Metabolism Conf., Second, Third & Fifth Wednesday, 7:30-8:30 a.m.
11. Dept. of Gynecology, Fourth Wednesday, 1-2:00 p.m.

### Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.  
1st—Dept. of Medicine  
2nd—Dept. of Surgery  
3rd—Dept. of OB/GYN  
4th—Dept. of Pediatrics  
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

### The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
  2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
  3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
  4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
  5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
  6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
  7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
  8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

## ANNOUNCEMENT

The Community Cancer Program of Hawaii Implementation Plan for the next period is being prepared. Funding levels are uncertain, but hopefully there will be sufficient funds for new projects. Proposals from community groups and agencies in the area of cancer control are encouraged. In preparing such proposals, several types of information are requested:

1. Which unmet cancer control need in a local region or group is being addressed.
2. A description of how the proposal demonstrates that coordination is superior to separate, uncoordinated programs in prevention, detection, management and continuing care.
3. Describe how the impact of the proposed program can be quantitatively evaluated.
4. In-kind matching contributions – for example time, space or materials – should be made by the proposer.
5. Describe the need for cancer control technology in a specific group and how the proposal will result in the transfer of such technology.
6. Describe the program's important impacts upon the cancer community: the patients, medical and allied health professionals.

For further information  
call 548-8422, or write Director,  
Community Cancer Program of Hawaii,  
1236 Lauhala Street, Honolulu, Hawaii 96813.  
A format for proposals may be obtained by writing the  
Community Cancer Program of Hawaii.

### St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. First 7:00 a.m.
3. Dept. of Med. Monthly Mtg. Second Tues. ea mnth. 7:30 a.m. Sullivan 4-classroom.
4. Surgical Grnd. Rnds. Fridays (except Fourth), 7:30-8:30 a.m. Sullivan 4-classroom.
5. Surg. Mortality & Morbidity Conf. Fourth Fri., 7:30-8:30 a.m. Sullivan 4-Classroom.
6. Hematology Conf., Third Thurs. ea. mnth. 12:30-1:30 p.m. Sullivan 4-Classroom.
7. Renal Conf. First Monday ea. mnth. 7:30-8:30 a.m. Sullivan 4-Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.
9. Pulmonary Conf. Second and Fourth Wed. ea. mnth. 12:30-1:30 p.m., Sullivan 4-classroom.
10. Endocrinology Conf. last Monday ea. month 12:30-1:30 p.m. UH-4 Classroom.

### Straub Clinic & Hospital

1. Anesthesia Conference meets the Second Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Community Peripheral Vascular Conference meets the Fourth Thursday of each month, from 4:30 to 6:30 p.m. in the DDR.
3. General Surgery Conference meets First, Second and Third Thursday of each month, from 7:00 to 8:00 a.m. in the ACR.
4. Hospital Quarterly Staff Meeting meets the Fourth Monday of the months of January, April, July and October, from 7:30 to 8:30 p.m. in the DDR.
5. Medical Grand Rounds meets the First Thursday of each month, from 7:00 to 8:00 a.m. in the DDR.

6. Neuropathology Conference meets the Third Thursday of each month, from 7:00 to 8:00 a.m. in the Morgue.
7. OB-GYN Pathology Review meets the Fourth Monday of each month, from 12:30 to 1:30 p.m. in the ACR.
8. Urologic Pathology Conference meets the First Friday of each month, from 8:00 to 9:00 a.m. in the DDR.
9. Friday Noon Conference meets every Friday, from 12:30-1:30 p.m. in the DDR.
10. Seminars in Human Performance & Environmental Physiology meets the Second Wednesday of each month, from 1:00 to 2:15 p.m. in the ACR.
11. Cardiac Surgery Conference meets the Second Tuesday of each month, from 4:30 to 5:30 p.m. in the DDR.
12. Surgical Morbidity & Mortality meets the Fourth Thursday of each month from 7:00-8:00 a.m. in the DDR.

### Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

### Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

### Miscellaneous

Hawaii Radiological Society meetings, Third Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Local Hospitals, Honolulu

Type: 1, 1 hr./day, 1 day/mo. from 12 mos.

Fee: None Methods: AV, O, Pan

Dates: All yr., 12 hrs. instruction.

### SPECIAL EVENTS

- |                   |  |
|-------------------|--|
| Jan. 6-13, 1980   | Ultrasound Conference, John A. Burns Schl of Med., co-sponsored by the Honolulu Medical Group, Research and Education Foundation, 18 Category I credit hours. Mauna Kea Beach Htl.                 |
| Jan. 6, 11, 1980  | Clinical Pharmacology for the Practitioner, The Am. Instit. of Postgrad. Ed. to be held at Maui Intercontinental Hotel. 21 hrs Cat. I.   |
| Jan. 8-12, 1980   | Intensive Review of Common Allergic & Asthmatic Diseases, U of Cal., Davis, Schl. of Med. Intercontinental Htl., Maui.   |
| Jan. 12-18, 1980  | Perinatal Medicine, USC. Held at Royal Lahaina, Maui. 20 hrs. Cat. I.  |
| Jan. 14-18, 1980  | 15th International Surgical Congress (Ten Surgical Specialties) Sheraton Waikiki, 20 Category I credit hours, Pan Pacific Surgical Association.  |
| Jan. 14-20, 1980  | Estes Park Institute, Kauai Surf Htl., Ms. Tomi Wilson, Admin. Dir., P.O.Box 400, Englewood, CO 80110.   |
| Jan. 15-22, 1980  | Iowa Lutheran Hsp. Med. Staff Postgraduate Seminar, Royal Lahaina, Maui.   |
| Jan. 18, 19, 1980 | Communication Disorders Workshop-Hi. Speech & Hearing Assoc./HMA. (1/18-1:30-9:30p.m.—1/19-8-4:00p.m.) total 12½ hrs. Cat. I. To be held at Waikiki Hyatt Regency Htl.                             |
| Jan. 19-21, 1980  | Common Obstetric and Gynecological Problems, co-sponsored by Tulane University School of Medicine, Department of Ob-Gyn, and Hawaii Section of ACOG, 15 Category I credit hours, 15 cognates ACOG. |

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- Jan. 28-31, 1980 19th Ohio St. Univ. Urological Outing, Kauai Surf, 16 hrs. Cat. I
- Jan. 26-Feb. 2, 1980 Nephrology, USC, Princeville, Kauai.
- Feb. 1-4, 1980 Hawaii Review, co-sponsored by the Hawaii Chapter of AAFP, with invitation to BC Chapter College of Family Physicians of Canada, and Section of General Practice, BC Medical Association.
- Feb. 4, 8, 1980 Surgical Diagnosis & Therapy, Phil Thorek Postgraduate Courses, Maui.
- Feb. 10-17, 1980 Otolaryngology Update, Hilton Hawaiian Village 10-14 & Kona Hilton, 14-17. U of C Dept. of Oto & Sacramento Soc. of Oto. Leslie Bernstein, M.D., D.D.S. P. O. Box 3213, El Macero, CA 95618.
- Feb. 11, 16, 1980 Surgical Pathology, Problems In. Kauai Surf, 32 hrs. Cat. I. Univ. of Chgo.
- Feb. 16-23, 1980 Postgraduate Course in Clinical Allergy, Maui Surf, 28 hrs. Cat. I. J.A. Burns School of Med.
- Feb. 16-23, 1980 Dilemmas in Obstetrics, U of Cal. San Fran. Held at Kauai Surf.
- Feb. 16-23, 1980 Physicians' Program in Undersea Med., Undersea Medical Society.
- Feb. 20, 1980 Symposium on Cisplatinum, Comm. Cancer Control Prog./HMA, 1-5:00 p.m., 4 hrs. Cat. I. To be held at Mabel Smyth Aud., Honolulu.
- Feb. 21-27, 1980 Professional Laboratory Management Institute, Am College of Pathologists, Sheraton Waikiki & Sheraton Maui.
- Feb. 23-Mar. 1, 1980 Intercontinental Conf. on Diagnostic Medicine, Ohio Acad. of Family Prac. Held on Maui.
- Feb. 25-Mar. 1, 1980 Recent Advances In Laboratory Medicine, 32 hrs. Cat. I, Univ. of Chgo. Held at Kauai Surf.
- Mar. 1-8, 1980 American Urological Association, Western Section, King Kamehameha Hotel and the Sheraton Waikiki.
- Mar. 1-8, 1980 Marquette-MCW Med Alumni Assoc. Clinical Conf. Held on Maui.
- Mar. 10-15, 1980 Diagnostic Radiology including Ultrasound & CT Scanning, Duke Univ. Med Centr. Held at Hyatt Regency, Waikiki.
- Mar. 18-22, 1980 Sports Medicine, Department of Physiology, Princess Kaiulani, 18 Category I credit hours. J. A. Burns School of Med. Contact: Harold Brown, Hawaii Conf. Serv. P. O. Box 25055, Honolulu 96825 (808) 377-6445.
- Mar. 19-25, 1980 Traveling Medical Education Course, Penn. Med. Society. To be held at Kauai Surf.
- Mar. 27-Apr. 4, 1980 9th Obstetrical Anesthesia Conf. Ohio St. Univ. College of Med., Marina Del Rey, CA. To be held at Sheraton Waikiki.
- Mar. 29-Apr. 4, 1980 Infectious Disease Conf., U of Wash. Schl of Med. to be held at Ilikai Htl. 20 hrs. Cat. I.
- Mar. 31-Apr. 4, 1980 Current Concepts in Obstetrics and Gynecology, John A. Burns Schl of Med., co-sponsored by the University of Washington, Dept. of Ob-Gyn and Hawaii Section of ACOG, Ilikai Hotel, 24 Category I credit hours, 24 cognates ACOG.

## OUT OF STATE

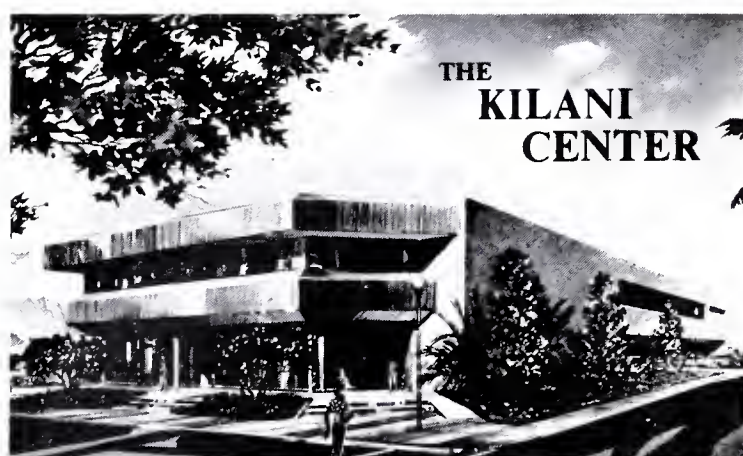
For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.



**Friday, November 2, 1979**  
**HMA CONFERENCE ROOM**

### PRESENT:

Drs. Bell, Winn, Lum, Goto, Chinn, Iaconetti, Chang, Azman, Miyashiro, Chun-Hoon, Lumeng, Shirasu, Bruce, Cahill, McNamee, Wigle, Fu, Mills, Dang, Sia, Simmons, and Mrs. Nancy Simmons. HMA



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Staff present were: Messrs. Won, Saranchock, Leineweber, and Mmes. Kendro, Chang, Wong, and Young.

**CALL TO ORDER:**

The meeting was called to order by President Bell at 5:55 p.m.

**MINUTES:**

The minutes of the previous meeting were approved as circulated.

**REPORT OF THE SECRETARY:**

The Council reviewed the report of the Secretary as of October 31, 1979 which indicated that HMA membership totaled 911 in comparison with October 1978 when membership totaled 904.

**REPORT OF THE TREASURER:**

The September 1979 financial statement was reviewed in detail and approved subject to audit.

**ELECTIONS:**

Since it is customary for the Council to annually elect members of the Finance Committee, Bureau of Research and Planning, representatives to the EMS Board, and officers of the Community Research Bureau, the Council reviewed the slate of nominations and elected the following by unanimous ballot as there were no additional nominations from the floor:

**Finance Committee**

Winfred Chang, M.D.  
William Dang, M.D.  
Henry Fong, M.D.  
Elmer Johnson, M.D.  
Ronald Peroff, M.D.

**Bureau of Research and Planning**

Ann Catts, M.D. (1982)  
John Kim, M.D. (1982)  
George Mills, M.D. (1982)  
Henry Oyama, M.D. (1982)

**HMA Representatives to the EMS Board**

Stanley Saiki, M.D., Chairman  
Herbert Chinn, M.D.  
Douglas Ostman, M.D.

**Community Research Bureau**

President—O. D. Pinkerton, M.D.  
Vice President—Herbert Chinn, M.D.  
Secretary—Rowlin Lichter, M.D.  
Treasurer—Grover Batten, M.D.

The Council also confirmed the following appointments of the President:

Calvin C. J. Sia, M.D., Chairman, Bureau of Research and Planning  
Drake Will, M.D., Chairman, Cancer Commission

**REPORTS OF COMMITTEES  
AND COMMISSIONS**

*A. Public Affairs:* TV-Radio: Dr. Philip McNamee provided the Council with an update on the TV series, "Your Body Your Mind." Inasmuch as funding from the Chamber of Commerce has run out, Dr. McNamee informed the Council that a commitment for funds has been received from HMSA, which would enable HMA to continue production and promotion of the series. In preparation for the new series, Dr. McNamee requested Council approval of the proposed agreement with Paul Berry Associates (production company).

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**ACTION:**

**It was moved, seconded, and passed to approve the agreement with Paul Berry Associates.**

Tel-Med: On behalf of Dr. Lichter, Mrs. Ceci Young reported that the Tel-Med Joint Executive Committee is proposing to hire an additional person to increase its hours of operation on a trial basis to include Saturdays from 9 a.m. to 5 p.m.

**ACTION:**

**It was moved, seconded, and passed to refer this matter to the Public Affairs Committee.**

*B. CME:* Dr. Nadine Bruce reported that HMA is due for reaccreditation in 1980. On behalf of the Committee, Dr. Bruce recommended that HMA charge a fee for co-sponsorship of CME programs and requested guidance from the Council regarding an appropriate amount.

**ACTION:**

**It was moved, seconded, and passed to recommend that the CME Committee work with staff and come back to Council with a recommended fee for co-sponsoring CME programs.**

*C. Health Services:* Mrs. Becky Kendro reported that the Health Manpower Committee has reviewed the draft SHCC Manpower Task Force report. SHCC has reviewed the report, and it will be scheduled for a public hearing in the near future. The Committee will have two special meetings with a representative from the School of Nursing to discuss nurse practitioners, and also with representatives from the physicians assistants association.

Dr. Sia pointed out that the Governor will soon be making appointments to SHCC and SACs and

suggested that HMA submit nominations in order that physicians can be represented in health planning matters.

**ACTION:**

**It was moved, seconded, and passed to refer this matter to the Community Health Care Committee to actively pursue representatives for each of the appropriate areas.**

Mrs. Kendro mentioned that she recently attended a National Voluntary Effort meeting.

*D. EMS:* Dr. Dang reported that the EMS program will be emerging with a final report on the program's activities this past year. It was noted that the program either trained or retrained 2,500 individuals during the year. Plans are being made to introduce legislation in the coming session to enable EMT's to do I.V. on the field. Dr. Dang mentioned that EMS is looking for a training coordinator.

*E. Legislation:* Dr. George Goto reported that the Committee is preparing for the next legislative session and will meet with Senate Health Committee Chairman, Senator Dante Carpenter, on generic drugs and ophthalmology; Representative Russell Blair on generic drugs; and Mr. Albert Yuen on chiropractors. In the Medicaid area, Dr. E. Lee Simmons mentioned that the Medicaid Committee will meet on November 7.

*F. Internal Affairs:* Dr. Neal Winn commented on the exhibits and attendance at the 123rd Annual Meeting. In 1980 HMA will sponsor the annual meeting alone as AMA will not be holding a regional CME meeting in Hawaii. Dr. Winn suggested that HMA hold a workshop on state and national health legislation in conjunction with the 1980 Annual Meeting.

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*G. Malpractice Insurance:* Mr. Jon Won stated that a "good news" bulletin has just been sent out to the membership to announce Argonaut's decision: (1) to reduce premium rates for physicians' professional liability insurance in Hawaii by 5%; and (2) to have physicians' professional liability insurance policies become "participating" policies in Hawaii.

*H. Fee Survey:* A suggestion was made that HMA consult with AMA regarding the printing of a RVS or procedural terminology manual in view of a recent decision regarding the anesthesiologists suit.

#### REPORTS OF COUNTY SOCIETY PRESIDENTS:

*A. Honolulu:* Dr. Walter Chang reported that Honolulu County will hold its next general membership meeting, "HMSA Update, 1979" on November 5, with guest panelists Mr. Albert Yuen, Mr. Bernard Ho, and Dr. William Sage. At this meeting, nominations from the floor will be accepted for HCMS elective offices and positions. The Society's Annual Meeting and installation of officers will be held on December 2, 1979 at the Honolulu International Country Club. Dr. Chang thanked the Council for making it possible for him to attend the AMA's Annual Meeting in Chicago and mentioned that it has been a most informative and rewarding year as HCMS president and as a member of the Council.

*Membership Incentive Program:* Mr. Jon Won announced that Honolulu County will launch its membership incentive program very shortly. Under this program, a physician member who recruits a new member into the HCMS, HMA, and AMA will receive a credit on his dues for the following year. For every full dues paying member recruited, AMA has approved a credit of \$50, HMA a credit of \$30, and HCMS a credit of \$20. Mr. Won commented that other county societies may wish to participate in this program.

*B. Maui:* Dr. Ben Azman mentioned that Maui County Society met on October 16 with guest speaker, Dr. LaSalle Lefall, President of the National American Cancer Society. Their next meeting is slated for November 20 with HMA's legal counsel, Mr. Tom Rice, as the featured speaker. On the agenda for this meeting will be discussion on whether the Society should become incorporated.

*C. Hawaii:* Dr. Arch Wigle reported that Hawaii County's next meeting is scheduled for November 15, at which time the Society will be visited by Dr. Douglas Bell and Mr. Jon Won, who will discuss current HMA activities and issues of concern. Last month Dr. Francis Pien spoke to the membership on infectious disease.

*D. Kauai:* Dr. Yonemichi Miyashiro reported that the Society held a joint meeting with the Kauai Lung Association, with a presentation by Jim Murphy (visiting professor) on the subjects of emphysema and bronchitis.

#### NEW BUSINESS:

*A. Auxiliary:* Mrs. Nancy Simmons reported that the Auxiliary is most appreciative of the HMA's increased funding, and its Finance Committee will be meeting shortly with HMA Treasurer, Dr. William Hindle. Mrs. Simmons noted that a number of national Auxiliary officers will be visiting in Hawaii during the AMA Interim Meeting.

*B. AMA Interim Meeting:* Dr. George Mills announced that AMA will hold its Interim Meeting of the House of Delegates on December 2-5, 1979 at the Sheraton-Waikiki Hotel. Issues to be deliberated are: foreign medical graduates, ethics, budget, catastrophic insurance, national cost containment bills, continuing medical education, etc. Members were urged to attend the scheduled sessions.

*C. AMA Study on Health Care in Jails:* Mr. Jon Won reported that AMA had received a grant from the Law Enforcement Assistance Agency and some time ago began a study on health care in jails. Since then AMA has started five pilot projects to study the health care available in jails, prisons, and juvenile correctional facilities. The program, which is now in its fourth year, has developed comprehensive standards for health care in jails. As funding is available, it has been proposed that HMA work with the agency responsible for the correctional institutions, DSSH, to review the level of health care in jails based on the standards recently adopted by the AMA House, with a view toward having these facilities become certified under the AMA program. It was the general feeling of the Executive Committee that this would be a worthy project for the HMA since it would benefit the community.

#### ACTION:

**It was moved, seconded, and passed that HMA express an interest in the project.**

*D. EMCRO:* A suggestion was made that (1) HMA pursue the completion of the EMCRO (Experimental Medical Care Review Organization) project; and (2) begin a study on quality of ambulatory care. The Council agreed that this matter be referred to the Bureau of Research and Planning for study.

Concern was expressed by members of the Council regarding the legal status of the confidentiality of PacPSRO data. Questions were raised about the relationship of HMA and PacPSRO, and it was felt that



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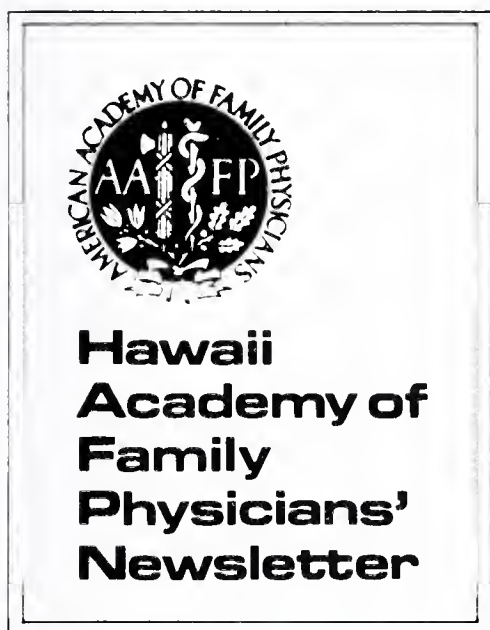
this relationship should be reassessed in light of these emerging concerns. It was noted that there is a contractual relationship and some shared staff between PacPSRO and HMA.

#### OTHER BUSINESS:

Dr. Sia announced that there will be a White House Conference on family in June 1980. Hawaii will have 10 issues presented and will have 12 delegates to the conference. Dr. Sia requested HMA input and support on any of the issues or nominations for delegates.

#### ADJOURNMENT:

The meeting adjourned at 8:30 p.m.



J. I. FREDERICK REPPUN, M.D.

#### New Members—Again, zero.

**News of Members**—**Donald Burlingame**, charter member from Hilo, has been elected to Life membership at the age of 81. So has **Bill Walsh**. **Lily Ning** has become an Active member; she plans to open her solo office in the QPOB (Queen's Physicians Office Building). **Glenn Stahl** was featured prominently in the Windward Unit Newsletter (W.U.N.) of the American Cancer Society, its first issue, as President of that unit. **Gwen Nishimura** made the Sunday paper (11/11/79) as having passed her ABFP boards and is certified as a specialist in Family Practice. **Jean Reppun**, our longtime ExecSec is giving up the job and turning it over to **Marlies Farrell**; at the same time husband **Fred Reppun** will not run for re-election as perennial treasurer; **Don Farrell** has been nominated to take his place.

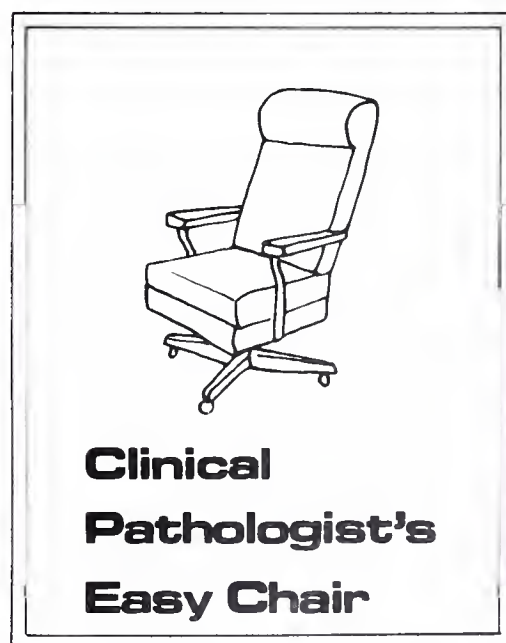
**Pan-Pacific Surgical Ass'n**—Fifteenth Congress in Hawaii 12-18 January 1980 has been approved by the regional commissioner for the Committee on Medical Education, AAFP, as Prescribed "P" credit. This is a considerable accomplishment, the result of the 1979 Congress of Delegates' change in the rules for credit hours.

**Other CME of Importance**—to members: The Minnesota Academy is putting on a "P" approved seminar on Maui 20-29 January 1980. Also on Maui at the Hotel Inter-Continental 27 Feb. to 5 March is a 32-hour "P" course on OB-GYN at \$385, which includes the hotel room. Again on Maui (Maui *no ka oi* must be the reason), the UH School of Medicine will present a PG Course in Clinical Allergy 16-23 February at the Maui Surf, Kaanapali for \$250 but AAFP credits have not been listed as yet.

**Hawaii Review**—a reminder: 1-4 February 1980 in conjunction with the BC Chapter, College of Family Physicians of Canada, at the Hilton Hawaiian Village.

**Annual Meeting**—for the Hawaii Chapter, election of officers and their installation by AAFP Pres. **Derryberry** will take place on Sunday, 3 February 1980 in the Coral Ballroom of the Hilton Hawaiian Village. After a no-host cocktail hour 6:30 to 7:30 PM there will be a nine course Chinese dinner for the visiting Canadians and for members of HAFP and their guests irrespective of whether members are signed up for the seminar or not, at \$15/each. This will include wine and music. Following the dinner, HAFP will conduct its business, necessarily very briefly but with full ceremony, in the presence of the Canadians. Following this, there will be a Hawaiian show and music for dancing.

**Slate of Nominees for 1980**—The Council has come up with the following: **Pat Dietrich** will be installed as President. For Pres-elect: **Jim Tsuji**. For Secretary: **Nathan Wong**. For Treasurer: **Don Farrell**. For Delegates to AAFP: **Tom Cahill** and **Don Farrell**. For Alternate Delegates: **Jim Tsuji** and **Kenneth Kern**. For Councillors to serve through 1982: **Lloyd Kobayashi**, **Fred Reppun** and **Harold Timboe**. **Joe Fitzharris**, whose term runs out, is nominated to succeed himself through 1981, replacing **Nat Wong**. **Doris Jasinski** is nominated to replace **Tom Cahill** as our nominee to the HCMS Board of Governors, Tom going up to be Secretary of that Board. An Alternate for Doris is being sought.



FRANCIS FUKUNAGA, M.D.

#### Ionized Calcium

Calcium in blood exists in 3 forms: (1) protein bound, approximately 40%; (2) ionized or Free Calcium, about 45%; and (3) complexed with citrate, lactate and sulfate, about 15%.

Ionized calcium is the only physiologically active portion, but the usual laboratory measurement is the sum of the 3 calcium states. The total calcium concentration cannot predict the ionized calcium level, especially in non-physiologic states.<sup>1</sup> The physiologic importance of ionized calcium is reflected by its extremely fine regulatory control, while total calcium exhibits significant variation from time to time.

The most common causes of abnormal ionized calcium are blood transfusions, diseases of the parathyroid glands, bones and kidneys. The most common results of abnormal ionized calcium are changes in neuromuscular activity, cardiac contractile and conductive activity, and parathyroid gland secretion.

Massive blood transfusions cause changes in the normal relationship of the 3 calcium states, and may cause abnormal cardiac contractions and conduction.

The excess anticoagulants present in stored blood can cause severe fluctuations in the ionized calcium levels; correction is best performed with accurate measurements of the ionized fraction, total calcium assays being of little value. The problem is greater in patients with liver or renal dysfunction.

Ionized calcium is a significantly more sensitive indicator of parathyroid gland dysfunction than are total calcium or parathormone assays, but all 3 form a complementary battery in the diagnosis. Measurement of ionized calcium is essential in those cases with normal or borderline total calcium levels.

Patients with chronic renal stone formation may show elevated ionized calcium, despite normal total calcium. Patients with renal insufficiency show binding of calcium ions; the ionized calcium levels tend to be disproportionately low and may be subnormal despite normal total calcium concentrations. Ionized calcium levels are used as guides in the prophylaxis of renal osteodystrophy.

Ionized calcium concentration cannot be reliably predicted, and the reliance on total calcium levels in certain diseases may make diagnosis and treatment difficult. Protein abnormalities cause poor correlation between total and ionized calcium. Patients with low total proteins may have normal ionized but depressed total calcium, while some patients, such as those with various cancers, may have normal total but elevated ionized calcium.

Newborns are subject to severe calcium-related trauma. Exchange transfusions with ACD-treated blood can cause significant ionized calcium decrease even though the total calcium levels may be increased.

Ionized calcium is ideally measured directly with a minimum of venous stasis. The measurement is done with ion-specific electrodes, and serum ionized calcium standards are used to calibrate the electrodes, because aqueous standards may give unpredictable results. Serum ionized calcium is pH dependent, being inversely related to the pH; the test is usually performed at pH 7.0. Blood must be collected and handled anaerobically, because blood pH rises when exposed to air. (There is approximately a 4% decrease of ionized calcium for each 0.1 pH unit increase.) Some authors feel that it is inappropriate for reference laboratories to perform this test, because of the required anaerobic handling and the changes that may occur with variations in the venipuncture that cannot be controlled from afar.<sup>2</sup> Others feel that blood can be refrigerated and plasma frozen or refrigerated without significant changes in ionized calcium levels if the original pH is restored with a CO<sub>2</sub>/air mixture.<sup>3,4</sup> Still others use a correction factor, employing pH and total protein concentration values on sera exposed to air.<sup>5</sup>

Normal values for serum ionized calcium varies from laboratory to laboratory, and must be established by each institution. The usual levels are 1.01 to 1.26 mM, or 2.02 to 2.52 mEq/L, or 4.04 to 5.04 mg/dl.<sup>6</sup>

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**Presented at** the opening session of the American Medical Association House of Delegates Interim Meeting held in Honolulu in December.

American Medical Association  
House of Delegates

#### *Commendation Resolution*

#### **Hawaii Medical Association**

Introduced by Student Business Section

WHEREAS, The Hawaii Medical Association has recognized the importance of medical student participation in the activities of the American Medical Association; and

WHEREAS, This recognition is vital to the functioning of the AMA Student Business Section; and

WHEREAS, The leadership and membership of the Hawaii Medical Association realize that full participation by medical students may be limited due to financial constraints; and

WHEREAS, The Hawaii Medical Association, in conjunction with the Honolulu County Medical Society, conducted a program to place students attending this 1979 Interim Meeting in the homes of member-physicians during their stay; therefore be it

**RESOLVED**, That the American Medical Association commend the leadership and membership of the Hawaii Medical Association and its component Honolulu County Medical Society for undertaking the initiative to enable medical students to participate in the 1979 Interim Meeting of the AMA House of Delegates by opening their homes to those students whose



limited financial resources would have otherwise precluded their attendance.

HARRISON L. ROGERS, JR., M.D.  
*Vice Speaker, House of Delegates*

WILLIAM Y. RIAL, M.D.  
*Speaker, House of Delegates*

## Medicine's Political Arm

To say medicine and politics are two separate and unrelated entities would be totally incorrect, and would indicate a lack of insight into the real world. To preserve the fundamental rights of physicians and their patients, the medical profession has banded together in recent years to insure that its voice is heard by those who govern. As a result, a number of positive legislative actions have been accomplished by organized medicine's political action committees. But their greatest accomplishments may be something you are unaware of—blocking negative legislation.

Literally hundreds of bills that would adversely affect organized medicine appear before legislators in Honolulu and Washington D.C. every session. Most die in committee, or are amended substantially at the suggestion of medicine's representatives. Issues such as licensure, discipline, Medicaid, advertising, HMO's, tort reform, scope of practice and confidentiality of records are only a few of the areas at which bills are aimed. Physicians rarely hear about bad legislation which could complicate their professional lives. Often such bills don't get far enough to attract public attention.

Political action committees have proven they can help stop dangerous pieces of legislation—or enact laws benefiting patients—because they effectively use physician resources to help elect and retain legislators who are sympathetic to medicine. Basically, these committees are formed to help elect “friendly” legislators. Unfortunately, not many physicians appear to be aware of the importance of political action since only one in every five physicians belongs to PACs on either the state or national level.

The local physicians' political action organization is the Hawaii Medical Political Action Committee (HAMPAC). It was formed in 1963, but now, nearly seventeen years later, many physicians believe there is more of a need for it than when it first began. There was once a time when organized medicine exerted a positive influence on government affairs with a modest investment of time and money. But this is no longer the case as groups such as the trial lawyers expend tremendous amounts of time and money to fight tort reform.

Why then is HAMPAC's and AMPAC's local membership so low? Is it because dues are so costly? Unlikely, since a year's voluntary mem-

bership in both HAMPAC and AMPAC is only \$20. Since it is to the advantage of every physician to belong to medicine's political action committees, the only logical explanation for such sparse membership is apathy on the part of physicians.

Through its contributions to local candidates, HAMPAC has been successful in obtaining favorable decisions at our local level of government, despite the low level of physician membership. Often the committee will aid a local candidate who cannot help medicine immediately. But when his career advances, HAMPAC hopefully is remembered for its previous help.

HAMPAC and AMPAC do not favor any one party; their politics are non-partisan. Contributions are based on how a candidate sides on issues that favor medicine and how responsive he is to the needs of the medical profession.

Back HAMPAC and AMPAC during this forthcoming election year and let the voice of medicine be heard because increasing government interference is beginning to effect us and our practices. Enclose your personal check for \$20 made out to HAMPAC at the time you forward your annual dues to your local Medical Society.

L. Q. PANG, M.D.  
Chairman, HAMPAC

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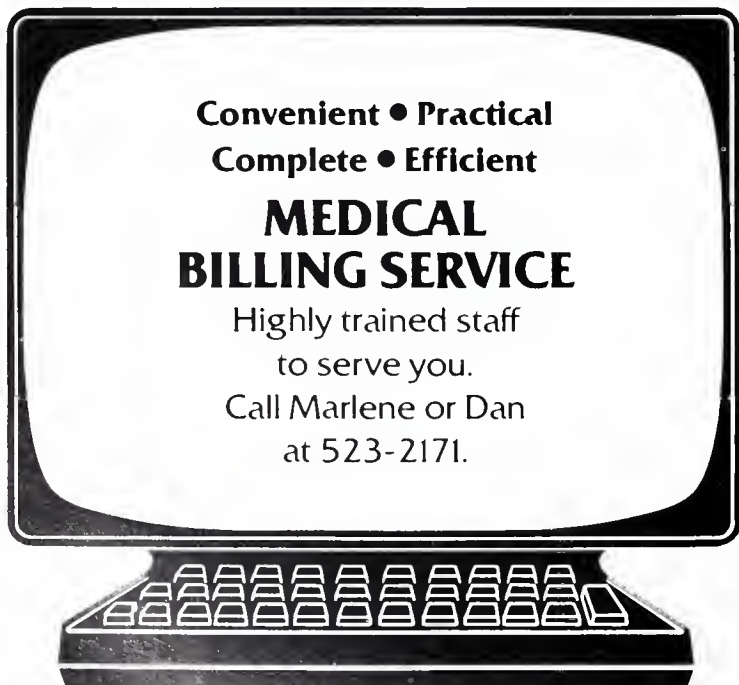
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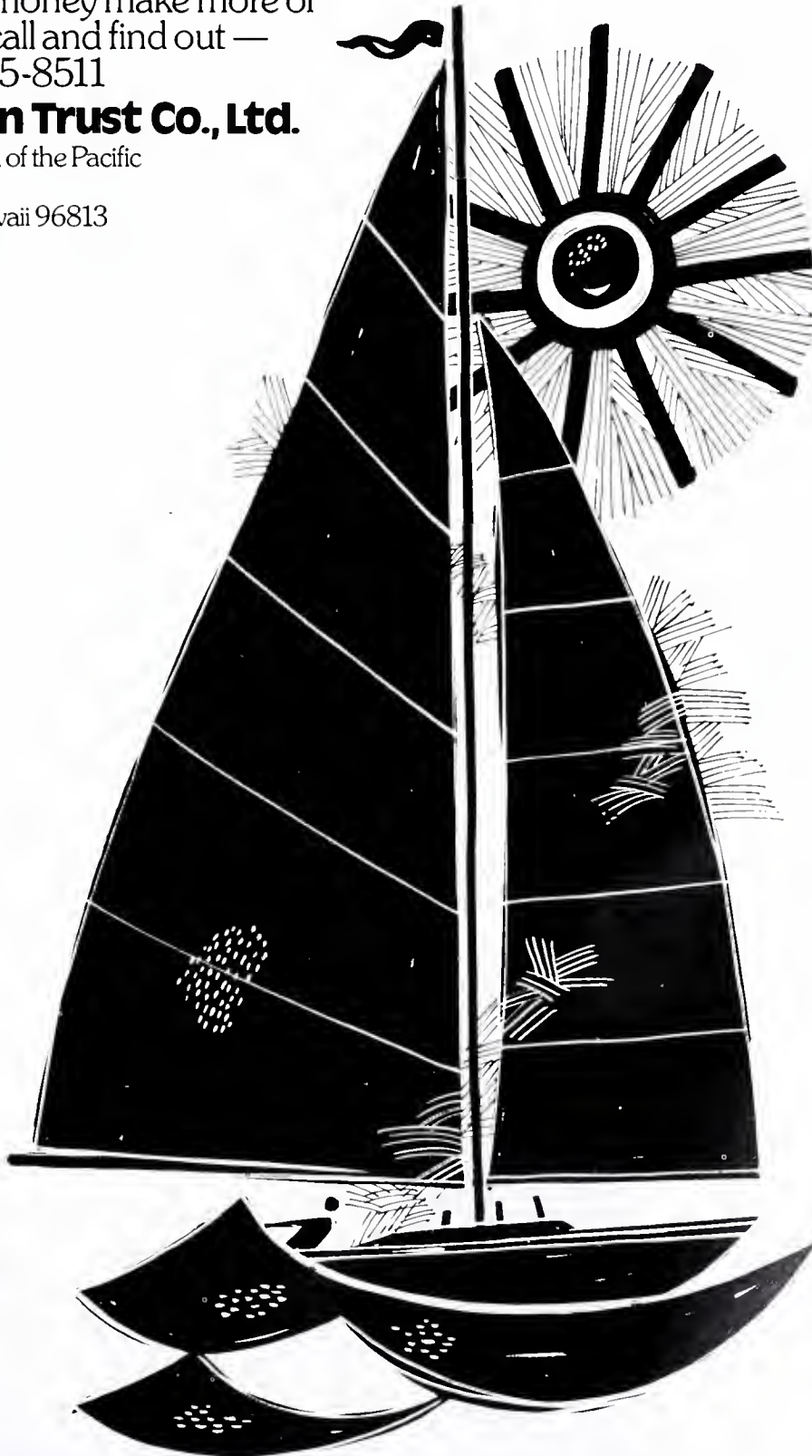
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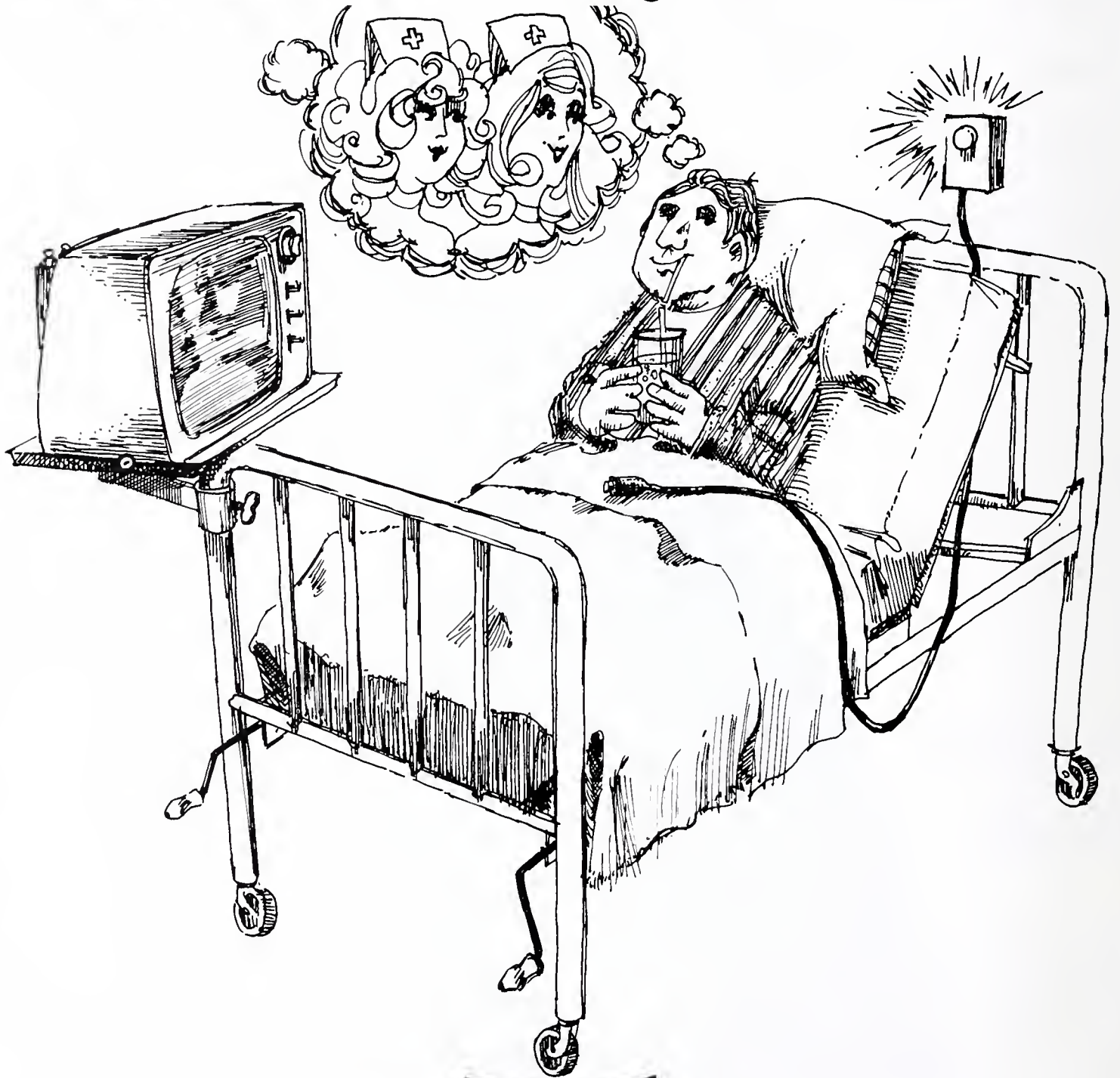
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